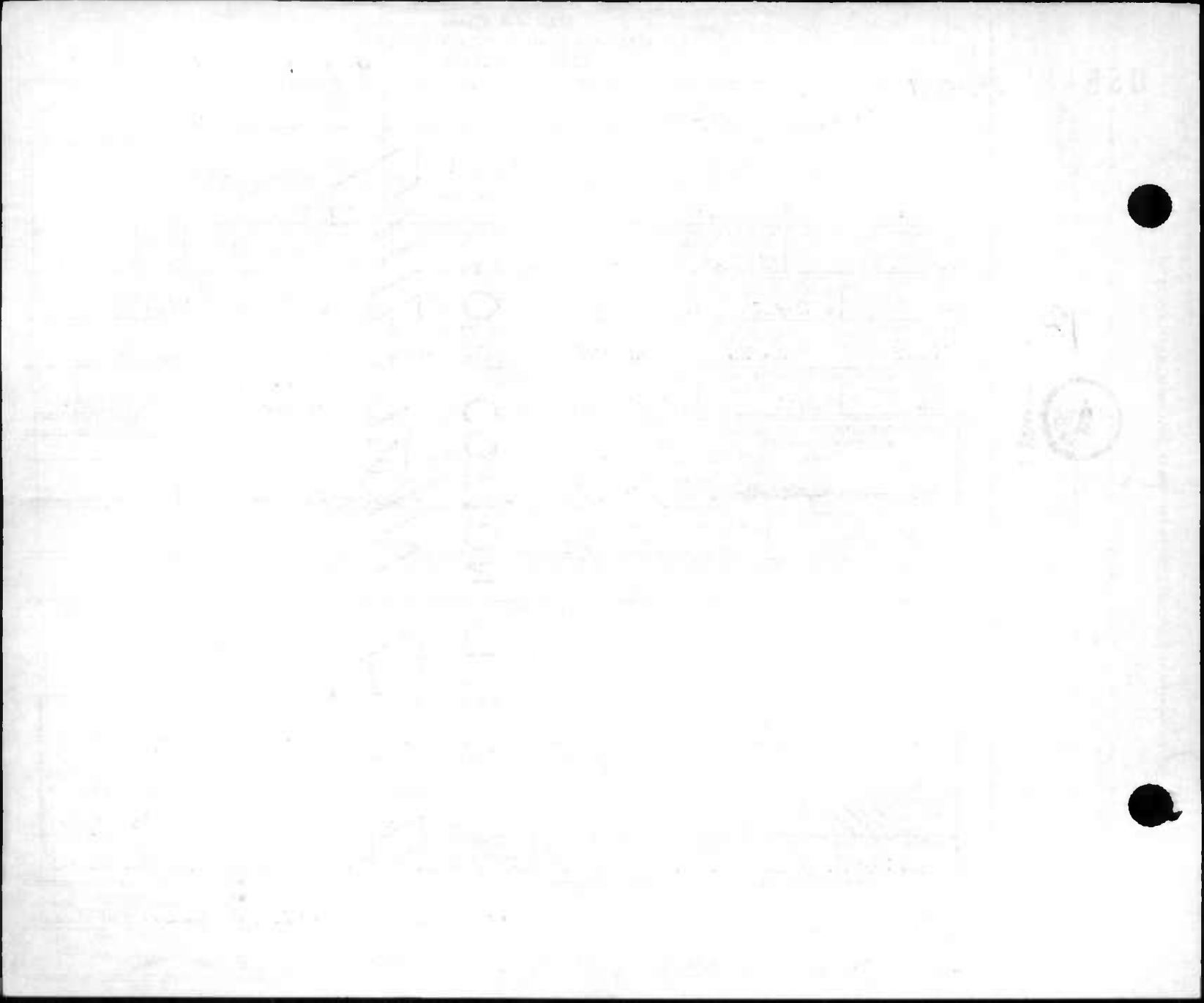


STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

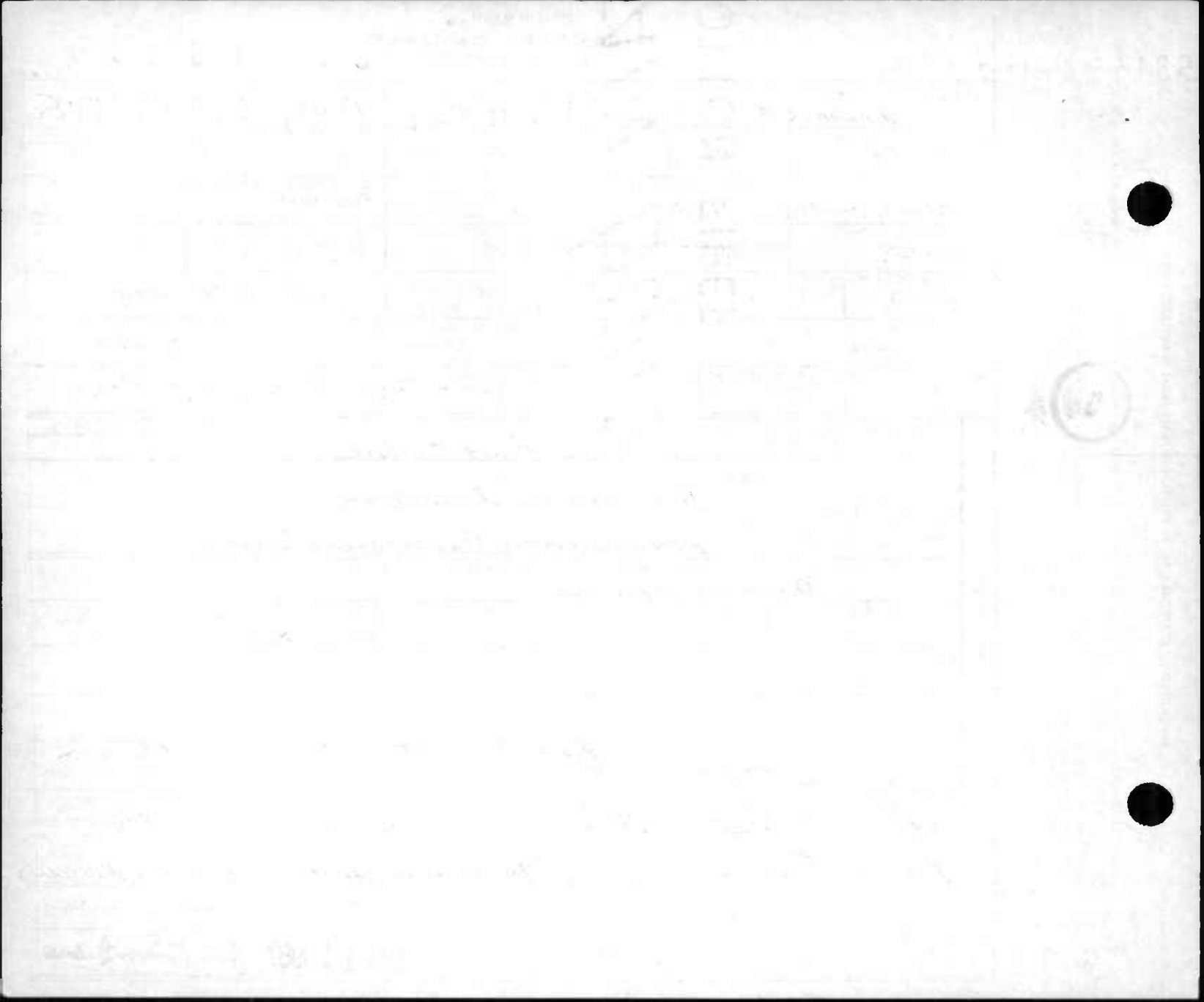
 8715498
 REG. NO.

| | | | | | | | |
|---|--------|--|--------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 2b. DATE OF DEATH | | 2c. HOUR | |
| BENJAMIN FULTON ADKINS | | 05 09 87 | | 3:55 PM | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| MALE | WHITE | JUNE 6, 1912 | 74 | MD | | USA | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SALISBURY | | SALISBURY NURSING HOME | | BUS DRIVER | | COMMERCIAL | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | | | |
| MD | | WICOMICO | SHARPTOWN | 302 FOURTH STREET/21861 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| LOUIS JAMES ADKINS | | BESSIE LEE MILLS | | YES | | WWII 214-12-6058 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| MARGARET G. ADKINS, SHARPTOWN, MD 21861 | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PARKINSON'S DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | YES | | NO | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHITE AT WORK | | | | STREET | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| 19 57, to 19 57, that (I) (we) last saw the deceased alive on 19 57, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | DEGREE | | ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| WILLIAM H. ROBINS M. D. | | CIVIC AVE. & RT. 50, SALISBURY, MD. 21801 | | JUN 1 1987 | | Julia Davidson-Rodgers | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 5-12-87 | | FIREMEN'S CEMETERY | | SHARPTOWN WICOMICO MARYLAND | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| ZELLER FUNERAL HOME, SHARPTOWN, MD 21861 | | JUN 1 1987 | | Julia Davidson-Rodgers | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15499
REG. NO.

| | | | | | |
|---|--|---|---|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Margaret Edna Alexander | | May 5, 1987 | | 1945 M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS (LAST BIRTHDAY)) | IF UNDER 1 YEAR | |
| Female | White | 09 21 1917 | 69 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Salisbury, Maryland | U.S.A. | | Wicomico MD | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | Peninsula General Hospital | Homemaker | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | Wicomico | Salisbury | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Leonard Lane 21801 | |
| 14 FATHER'S NAME | 15 MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | | |
| Charles Mitchell | Lucy Timmons | No | | | |
| 16b. SOCIAL SECURITY NO. | 17 INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | | |
| 217-14-8145 | Mrs. Joanne Coffin (Daughter) | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | 1509 S. Division St., Salisbury, Md. 21801 | (b) <u>MYOCARDIAL INFARCTION</u> | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>APRIL 16</u> , 19 <u>87</u> , to <u>MAY 5</u> , 19 <u>87</u> , that (he) (she) last saw the deceased alive on <u>MAY 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | | | |
| Allen W. Tustin, M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 5/6/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| Allen W. Tustin | 7A MEDICAL CENTER NORTH, SALISBURY, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 05.09/1987 | Parsons Cemetery | Salisbury, Wicomico, Maryland | | |
| 24 FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | |
| Holloway Funeral Home, P.A., Salisbury, Maryland | MAY 11 1987 | Julia Sanders-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15500
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harley James BAKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 12 87 | | | 2b. HOUR 1515 M | | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR August 9, 1910 | | 6 AGE (IN YEARS EAST BIRTHDAY) 76 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY construction | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Berlin | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Wilber Baker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Davis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 201 10 8765 | | 17 INFORMANT ADDRESS Clara Collins Rt. #1, box 292 Pittsville, Md. 21850 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Valvular Heart Disease & atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Fibrosis</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/12</u> 19 <u>87</u> to <u>5/12</u> 19 <u>87</u> , that (1) <u>last</u> saw the deceased alive on <u>5/12</u> 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>did</u> (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>D. SAGGAR</u> | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) D. SAGGAR M.D. | | | | 22d. ADDRESS Salisbury, Md. | | 22e. DATE SIGNED 5/12/87 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md. | | |
| 24 FUNERAL DIRECTOR NAME W. Kirk Burbage | | | | 108 Williams St. ADDRESS Berlin, Md. 21811 | | 25a. DATE REC'D BY REGISTRAR MAY 15 1987 | | |

9113

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15501

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leslie John BARRALL | | 2a DATE OF DEATH MONTH DAY YEAR MAY 3, 1987 | | 2b HOUR 1723 M | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10 CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed | | 12b KIND OF BUSINESS OR INDUSTRY Refrigeration | |
| 13a STATE Delaware | | 13b COUNTY Sussex | | 13c CITY OR TOWN Delmar | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Walter D. Barrall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie S. Barrall | | 13e STREET ADDRESS / ZIP CODE Rt. #2 19940 | | 99999 | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO. WW II | | 17 INFORMANT ADDRESS Laura C. Barrall Rt. #2 Delmar, De. 19940 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent Ischemic Ulcer.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | |
| 19a DATE OF OPERATION 5/2/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemic Ulcer. | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 7b, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/2/87</u> to <u>5/2/87</u> that (I) (we) lost saw the deceased alive on <u>5/2/87</u> above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE <i>[Signature]</i> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/3/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) PAROUK A. SUKANI | | 22e ADDRESS 560 Riverside Dr. A201. Salisbury | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Delmar, Sussex Delaware | |
| 24 FUNERAL DIRECTOR NAME Short Funeral Home, Inc. Delmar, De. 19940 | | | | 25a DATE REC'D. BY REGISTRAR MAY 6 1987 | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

1190

THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY
JANUARY 10, 1900
TO THE
COMMISSIONER OF THE
LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the application of the State of New York for the purchase of the land owned by the State of New York, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

Very respectfully,
J. B. ALLEN,
Attorney General.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15502

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Henry Bartlett | | 2a. DATE OF DEATH MONTH DAY YEAR May 30, 1987 | | 2b. HOUR 0300 M | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN 25 1927 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Salisbury | | 13b. COUNTY SAXIS | | 13c. CITY OR TOWN SAXIS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES BARTLETT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VANESSA LUMREE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 364-28-0012 | | 17. INFORMANT ADDRESS Mildred V. Bartlett Same as 13c. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Liver Failure & metabolic disorders DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis - Chronic hepatitis B | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Tonight 2 days years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Recurrent Pulmonary emboli, Atherosclerosis, Cholesterolosis Atherosclerosis, Ischemic bowel | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25/87 , 19 87 , to 5/30 , 19 87 , that (I) (we) last saw the deceased alive on 5/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J. P. Meadows | | DEGREE M.D. | | 22c. DATE SIGNED 5/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. Meadows M.D. | | 22e. ADDRESS 560 Riverside Dr. Box 2 Salisbury Md 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial | | 23b. DATE 6/2/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowbrook Mem'l Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md Wicomico | | 23e. DATE REC'D. BY REGISTRAR JUN 2 1987 | | | |
| 24. FUNERAL DIRECTOR NAME Baker & Bouds | | 25. REGISTRAR'S SIGNATURE J. P. Meadows | | | |

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15503

| | | | | | |
|---|------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Beatrice | | 2a. DATE OF DEATH MONTH DAY YEAR 05-30-87 | | 2b. HOUR 1315 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 01 31 1907 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Troy, New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Eden | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bussey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha VonEppinghausen | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 171-20-4759 | | 17. INFORMANT Cyril F. Barton (Husband) Same as #13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diverticulitis, osteoarthritis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5:26</u> to <u>5:30</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE MD | | 22c. DATE SIGNED 6-1-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Frank MD | | 22e. ADDRESS Suite 7, Medical Center, Salisbury, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 05/31/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory | |
| 23d. LOCATION CITY OF TOWN COUNTY STATE Salisbury, Wicomico, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1987 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

BP

4



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15504

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELWOOD C. Beach | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-87 | | 2b. HOUR 11:10 A.M. |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1-31-1950 | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA | | 13b. COUNTY Accomack | 13c. CITY OR TOWN Accomac | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE US Rt. #13 23301 99999 |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lowell Beach | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 228-72-6951 | 17. INFORMANT ADDRESS Mary V. Beach PO Box 232 Accomac, VA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cholangiocarcinoma, Metastatic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/12 1987, to 5/10 1987, that (I) (we) last saw the deceased alive on 5/12 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE David E. Cowall, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 5-12-87 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 145 E. Carroll St Salisbury, MD 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5-17-87 | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Bapt. Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Wardtown, VA | | |
| 24. FUNERAL DIRECTOR NAME C. C. Humbles Funeral Service | | ADDRESS Accomac, VA | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1987 | 25b. REGISTRAR'S SIGNATURE Julia Swinson-Roads |

180/20

180/20

180/20



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

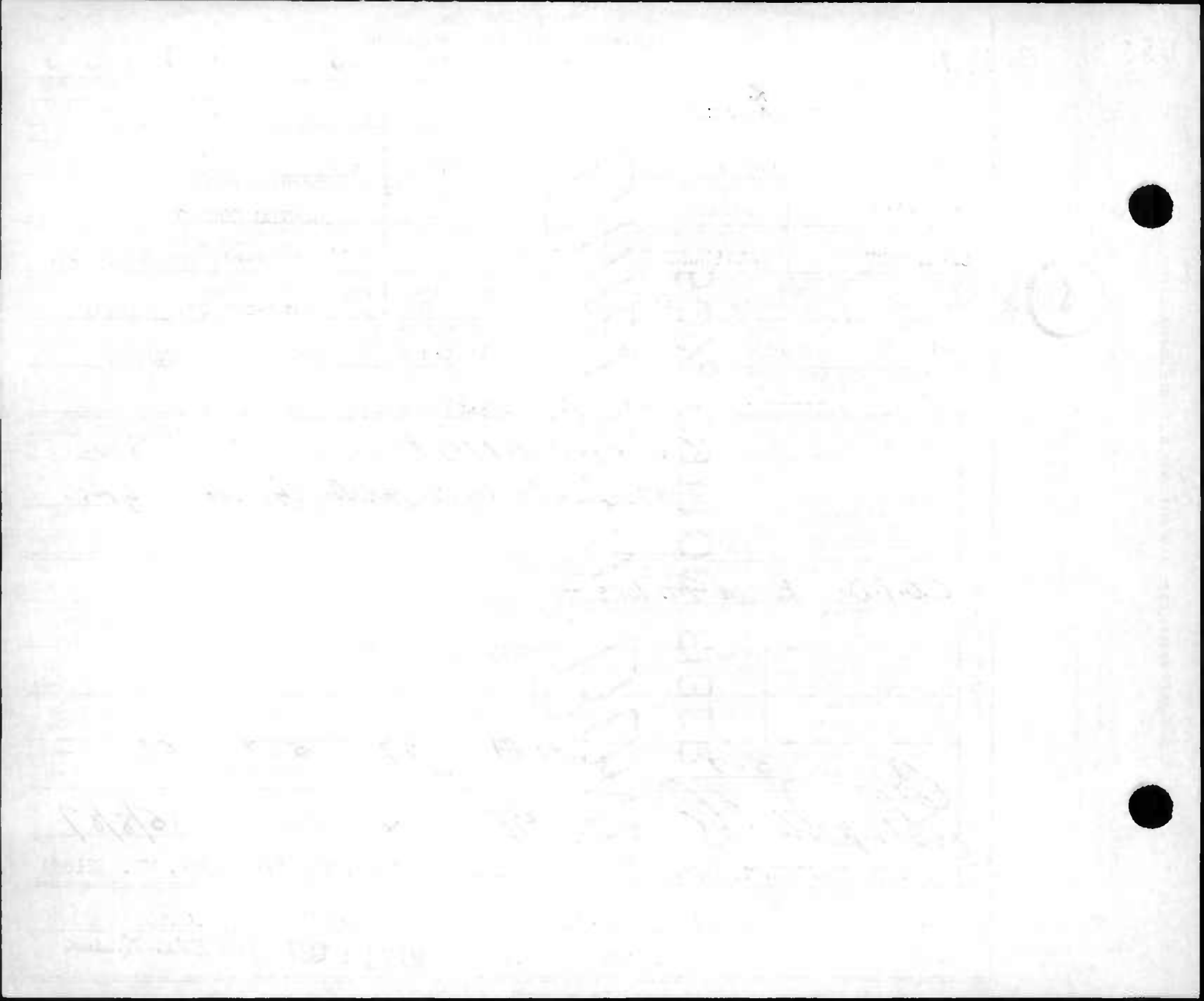
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in all the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and place them in the envelope within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. 87-15505 | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EUNICE BEASLEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-7-87 | | | | | | 2b. HOUR MIN 3:30 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 30 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD | | | | | | | |
| CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Seamstress | | | | 12b. KIND OF BUSINESS OR INDUSTRY Shirt Co. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John R Robert Beasley | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 178 Roseberry Dr. 21801 | | | | | |
| 10a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 10b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT Virginia Hayes | | ADDRESS Same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: C.O.P.D. Renal Failure - | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-21 19 87, to 5-7 19 87, that (I) (we) lost saw the deceased alive on 5-7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) not view the body after death. | | | | | | | | | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE/SIGNED 5/8/87 | | | | | |
| 23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23c. DATE 5-9-1987 | | 23d. NAME OF CEMETERY OR CREMATORY WICIMICO MEM. PARK | | 23e. LOCATION CITY OR TOWN COUNTY STATE SALISBURY WICOMICO MD | | | | | |
| 24. FUNERAL DIRECTOR BAKER AND BOUNDS | | | | SALISBURY, MARYLAND | | | | 25a. DATE REC'D BY REGISTRAR MAY 11 1987 | | | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Landrum | | | | | |



054229 MAY 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15506
REG. NO.

| | | | | | | | |
|---|--|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Georgie Iola Billups | | | | April 29 1987 | | 0435 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | Negro | Jan. 6, 1902 | | 85 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | U.S.A. | | | Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | Peninsula General Hospital | | | Domestic | | Cook | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. STATE | 13c. COUNTY | 13d. CITY OR TOWN | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. Worcester | Md. | Pocomoke | | 420 Linden Ave. 21851 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | | | | |
| Hiliary Gillette | Mamie Hall | | 002-36-8413 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | | | |
| No | 002-36-8413 | Tola Weaver | | 1836 Mat zero Rd. Apt. 1427 Adelphi, Md. 20783 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | |
| IMMEDIATE CAUSE (a) Hypoxia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| Severe bilateral pneumonia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| Gen. arteriosclerosis, Gangrene left 2nd toe s/p Fam Pop by pass 4/87 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | 4/28 | | 4/29 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/28 19 to 4/29 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| [Signature] | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 4/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| BAL AGARWAL | | PQHMC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPELLED) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5-2-87 | | Hall's Hill Cem. | | Pocomoke Wor. Md. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Amuel H. Savage | | New Church, Va. | | MAY 20 1987 | | Julia Dindon-Rudner | |

BP

054720

1. The first part of the report is a general description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is very small, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path. The area is very isolated, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path.

2. The second part of the report is a description of the people. They are a very primitive people, and they have no modern amenities. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path. The area is very isolated, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path.

3. The third part of the report is a description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is very small, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path. The area is very isolated, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for their goods. The only way to get to the area is by a narrow path, and the only way to leave is by the same path.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

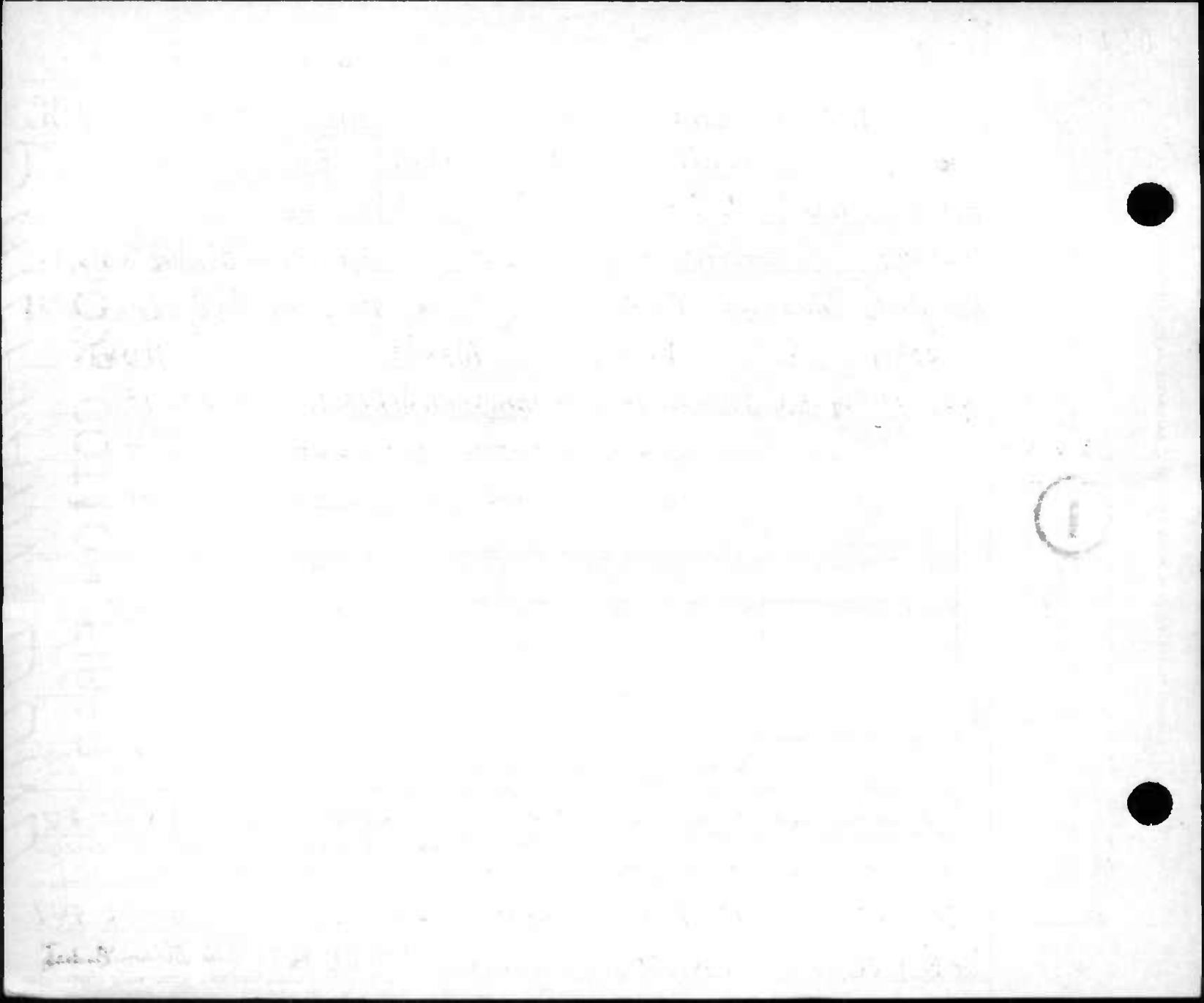
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove the permit from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21b, then any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 15501 | |
|--|--|--|---|---|--|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Gene Black | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 15 1987 | | | 2b. HOUR 3 30 AM | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6 11 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 54 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) High Point N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ext. Officer Dental Activity | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS & ZIP CODE 108 Covered Bridge Lane 21826 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John E. BLACK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude HUNT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes 1940-44 - Retired 1982 | | | | 16b. SOCIAL SECURITY NO. 237-42-0520 | | 17. INFORMANT ADDRESS BARBARA J. BLACK See Sec 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SHY DRAGAGE SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HRS 45 HRS | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-4, 1987, to 5-15, 1987, that (I) (we) last saw the deceased alive on 5-14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard E. Bird MD | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-15-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Bird M.D. | | | | | | 22e. ADDRESS 560 RIVERSIDE DRIVE B-204 Salisbury, MD 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 5/15/1987 | | 23c. NAME OF CEMETERY OR CREMATORY DeLmarva Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Baker & Bounds Salisbury, MD 21801 | | | | | | 25a. DATE REC'D BY REGISTRAR MAY 20 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | |



Item 13e per phone STATE OF MARYLAND
FOR 1- STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR 6/3/87 ~~210~~ CERTIFICATE OF DEATH

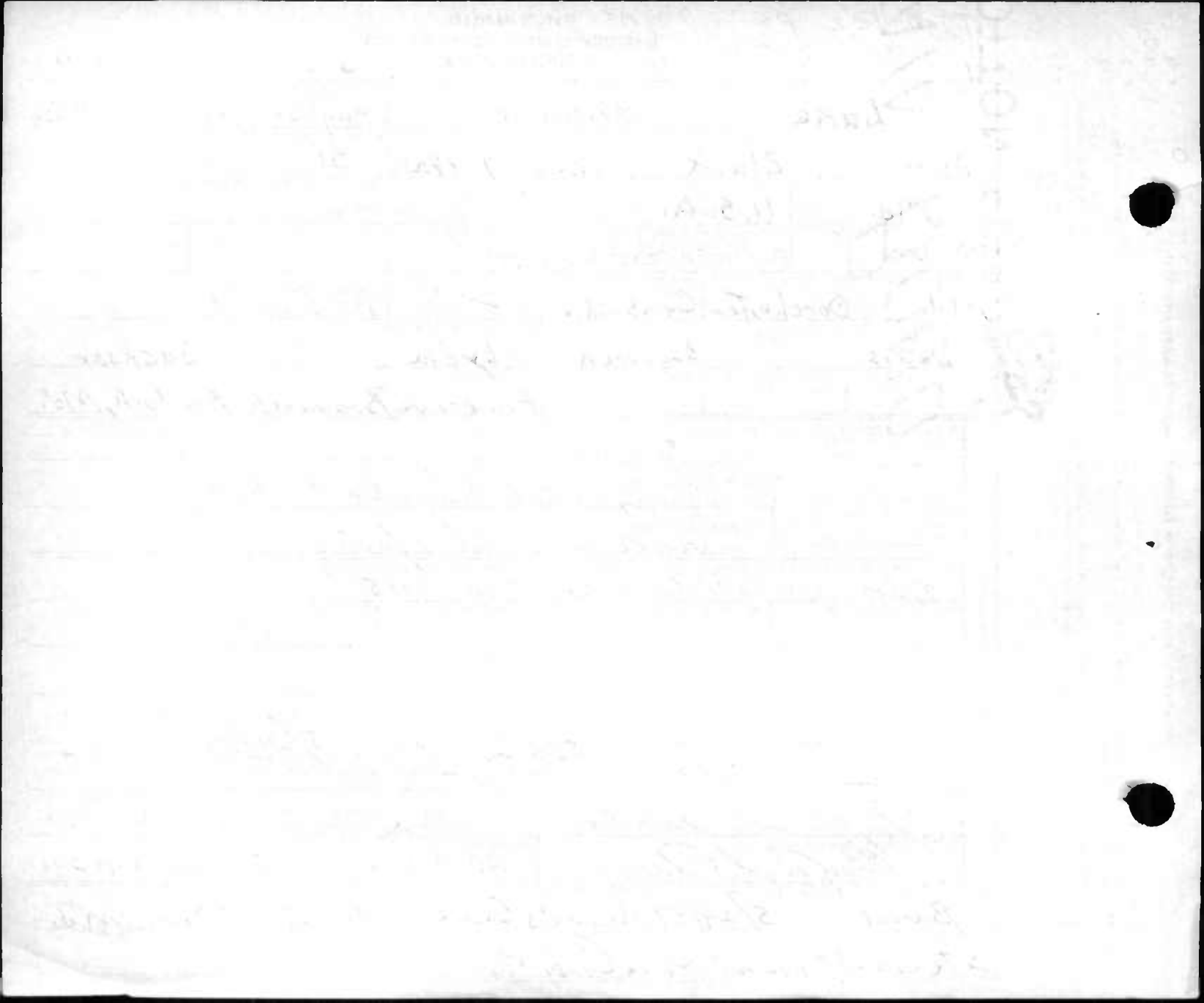
87 REG. NO. 15508

| | | | | | |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Luke Brannock | | | 2a. DATE OF DEATH MONTH DAY YEAR May 24 1987 | | 2b. HOUR 0523M |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Dec 7 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Dorchester 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Brannock | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Jackson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Francesine Brannock Hurlock, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Asymptomatic Tachycardia & fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Prior Aortic Valve replacement in 1985 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22 1987 to 5/24/87 , that I saw the deceased alive on 5/23 19 , and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles L. Roach | | | | 22c. DATE SIGNED 5/24/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Roach | | | | 22f. ADDRESS PO Box 2636 Salisbury MD 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY Love's Lane | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Taylor Island 2c Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS Stewart Funeral Home Camb, Md. | | | |
| 25a. DATE RECEIVED BY REGISTRAR JUN 1 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, it must be notified to the medical examiner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and attach them to the certificate. The certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, and 4 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

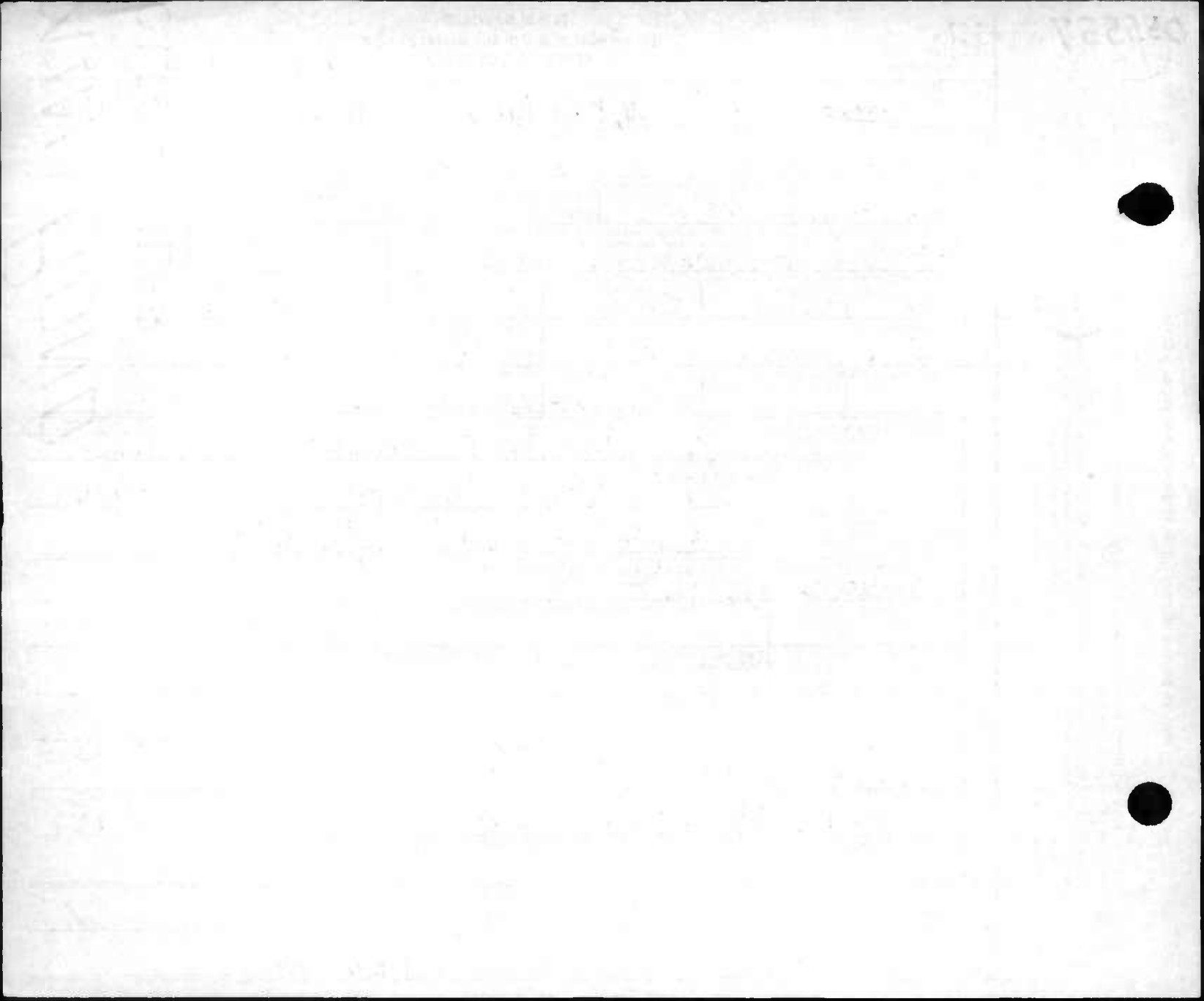
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 15509

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST First MIDDLE Addie M. LAST BRICKKOUS | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 27, 1987 | | 2b. HOUR 1900 M |
| 3. SEX Female | 4. RACE Blk | 5. DATE OF BIRTH MONTH DAY YEAR 7 3 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mandela Springs | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Columbus Albert Wilson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Etta Furr | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 213-24-1443 | | 17. INFORMANT ADDRESS Wesley Brinkous 812 Oneda Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Systemic Lupus Erythematosus | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1987, 19, to 5-27, 19-87, that (I) (we) last saw the deceased alive on 5-27, 19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE Roger Merzello | | | DEGREE MD | | 22c. DATE SIGNED 5-27-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-1-87 | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wicomico Md. |
| 24. FUNERAL DIRECTOR NAME A.E. Ward Funeral Home West Rd. & South Street | | | 25a. DATE REC'D. BY REGISTRAR JUN 4 1987 | | 25b. REGISTRAR'S SIGNATURE T. R. Radabaugh |



053016 MAY 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 15510

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Ellen Galloway | | 2a. DATE OF DEATH MONTH DAY YEAR May 4 1987 | | 2b. HOUR 1440 M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 07 24 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsville, Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS / ZIP CODE Cobbs Hill Road 21874 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harold B. White | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva Truitt | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 220-01-9895 | | 17. INFORMANT John Wayne Galloway (Son) | | 17b. ADDRESS Rte #1 Box 311A, Pittsville, Md. 21850 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) 96 hours | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 96 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 4-50 , 19 87 , to 5-4 , 19 87 , that (I) (we) last saw the deceased alive on 5-4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE James Spence, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 5/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS 307 Kay Avenue, Salisbury, Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/7/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Whitesville, Sussex, Delaware | | 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | | | |

MEDICAL CERTIFICATION

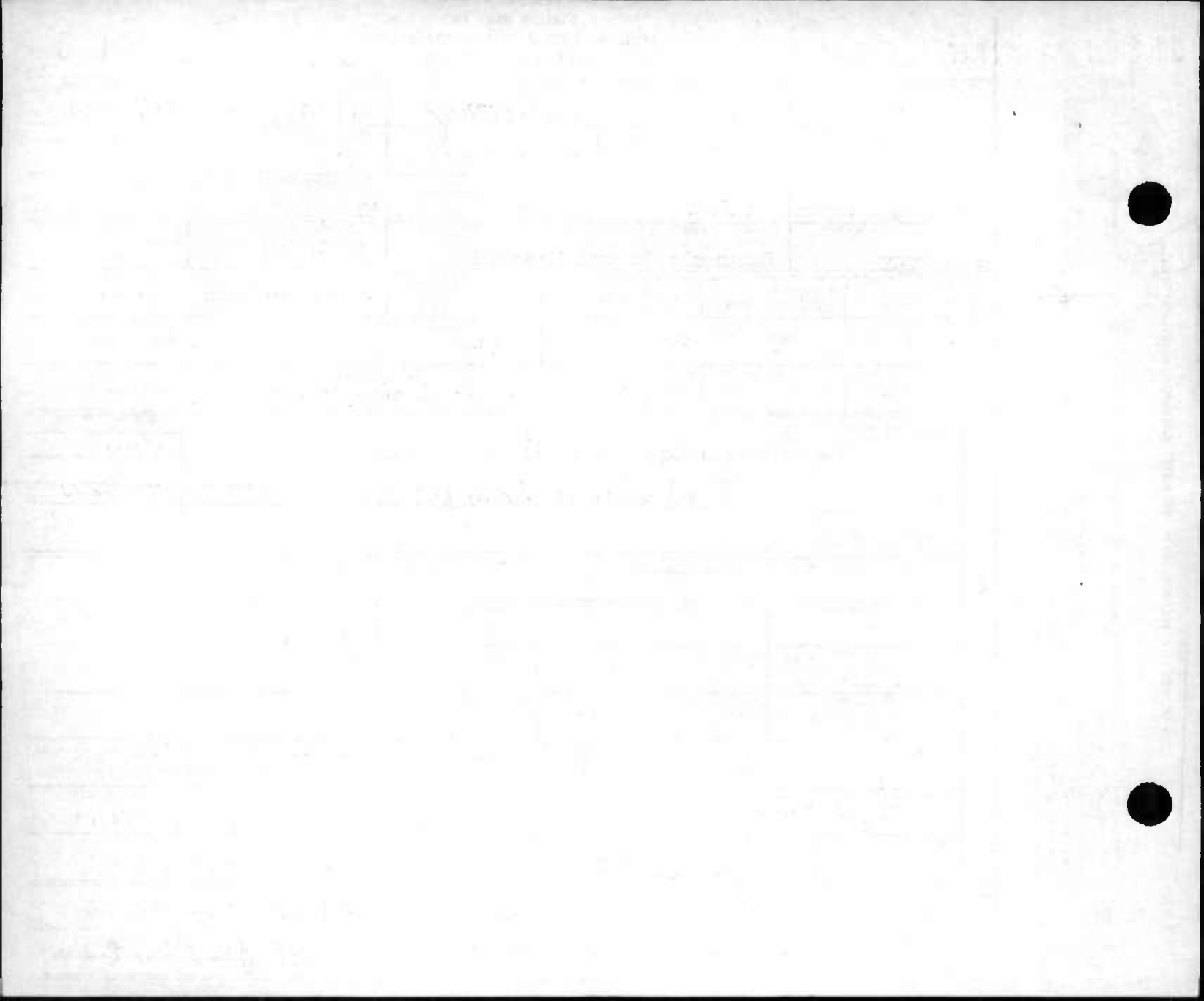
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



054230 MAY 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 87 15511

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Juan Cay-Rivera | | | 2a. DATE OF DEATH MONTH DAY YEAR May 14, 1987 | | 2b. HOUR 6:30 A.M. |
| 3. SEX Male | 4. RACE Puerto Rican | 5. DATE OF BIRTH MONTH DAY YEAR October 13, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Delaware | | | 13b. COUNTY Sussex | 13c. CITY OR TOWN Seaford | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Julio Cay | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 581-09-4682 | | 17. INFORMANT ADDRESS Ivan Cay 709 Clarence St., Seaford, DE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EAR ADVANCED CANCER OF ORAL CAVITY 14R 6mos.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>TRACHEAL COMPRESSION OF TRACHEA 6mos</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>ESOPHAGUS REQUIRING TRACHEOSTOMY & GASTROSTOMY.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CANCER OF ORAL CAVITY</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 27</u> , 19 <u>87</u> , to <u>14 MAY</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>13 MAY</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>W. Charles Schaefer</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>5-14-87.</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. CHARLES SCHAEFER.</u> | | 22e. ADDRESS <u>560 B102 RIVERSIDE DR SALISBURY MD. 21801.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>May 17, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cementio de Juncos</u> | |
| 23d. LOCATION CITY OR TOWN <u>Juncos</u> | | COUNTY <u>PR</u> | | STATE <u>PR</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Clarence E. Guff</u> | | ADDRESS <u>526 Union St., Milton, DE</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 21 1987</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Dickinson-Pendley</u> | |

05720

1-6 (21 m 11 1/2)

1-6 (21 m 11 1/2)

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054066 MAY 21 1987

Film #G628, Item #5, 6/16/87, sjb
 FOR Item #5,6 Film G628
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5512

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Ashmore BAILEY Christopher | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 13 1987 | | 2b. HOUR M 9:20P M |
| 3. SEX MALE | 4. RACE CAUS. | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1901 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 89.86YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 13 1987 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE CALIBRATOR TEST EQUIP, NT AIRPLANES | |
| 12b. KIND OF BUSINESS FARMS | | 13. STREET ADDRESS 609 RODNEY ST. SEAFORD, DELAWARE | | | |
| 13a. CITY OR TOWN SEAFORD | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME ASHMORE BAILEY CHRISTOPHER | | 15. MOTHER'S MAIDEN NAME LILLIAN McNEILLY CHRISTOPHER | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 156 05 5726 | | 17. INFORMANT LILLIAN C. YORK 609 RODNEY ST. SEAFORD, DELAWARE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neck injuries with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic cardiovascular disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:25 PM 4-24-87 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:25 PM 4-24-87 | | | |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21d. PLACE OF INJURY (AT HOME, STREET, PUBLIC PLACES, ETC.) road | | | |
| 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto/auto collision | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Market St. & High St., Seaford, Delaware | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5-14-87 | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 16, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEM. | |
| 23d. LOCATION (CITY OR TOWN) SEAFORD | | 23e. COUNTY SUSSEX | | 23f. STATE DELAWARE | |
| 24. FUNERAL DIRECTOR NAME JOHN R. MERCERON | | ADDRESS SALISBURY MD. | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia D. R. R. R. | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15513

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Louise COLE Cole | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1987 | | 2b. HOUR 1:50 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 13 1916 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 71 | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Private Sitter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Route #1 Box 624 21801 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Furbush | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie A. Majors | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | 16b. SOCIAL SECURITY NO. 217-07-2845 | | 17. INFORMANT S. John Cole (Husband) Same as #13e ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE Roger Ray, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED 5/24/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Ray, M.D. | | 22e. ADDRESS Kay Avenue, Salisbury, Md. 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 05/23/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron, Wicomico, Maryland | | 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

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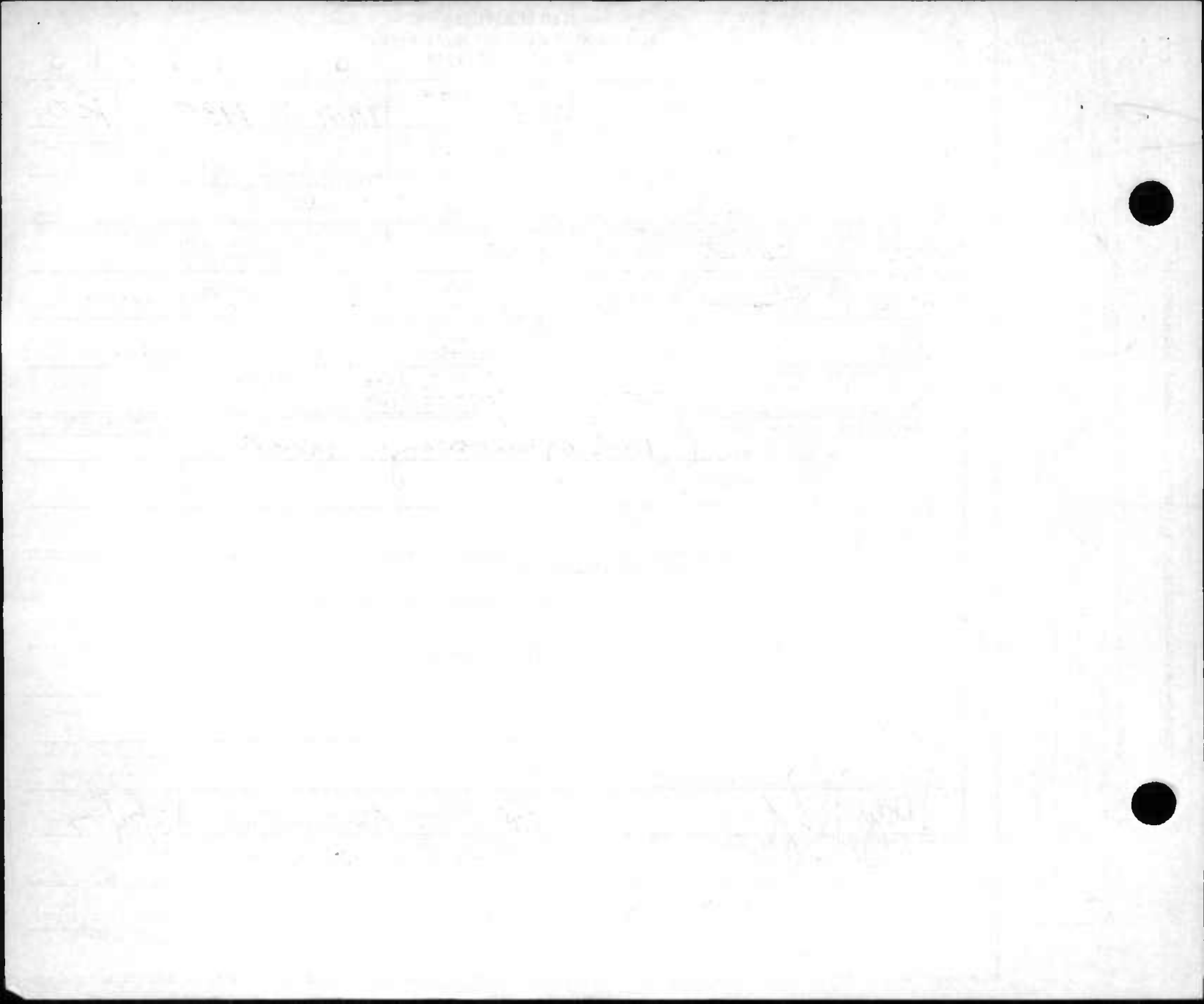
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted and the body must be autopsied.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 87 15515 | |
|--|--|---|---|---|--|--|--|--|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah Helen Coleman | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 4 1987 | | | 2b. HOUR 1300 M | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR July 12, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Mardela Springs 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 13e. STREET ADDRESS / ZIP CODE P.O. Box 90 Main Street 21837 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wiley Mishoe | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Cannon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT Ronald T. Coleman | | ADDRESS Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pleural effusions</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ignatius L. Dinardo | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/4/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ignatius L. Dinardo M.D. | | | | | | 22e. ADDRESS Somerset Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE May 8, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Gravel Hill Cemetery | | 23d. LOCATION CITY OR TOWN STATE Bloomington, Ga. | | | | |
| 24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 6 1987 | | 25b. REGISTRAR'S SIGNATURE John F. ... | | | |
| ADDRESS Arlington, Va. 22201 | | | | | | | | | | | |

MEDICAL CERTIFICATION

Handwritten notes and diagrams, including a large 'X' shape and various lines and arrows.

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Handwritten notes and diagrams, including a large 'X' shape and various lines and arrows.

Handwritten notes and diagrams, including a large 'X' shape and various lines and arrows.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

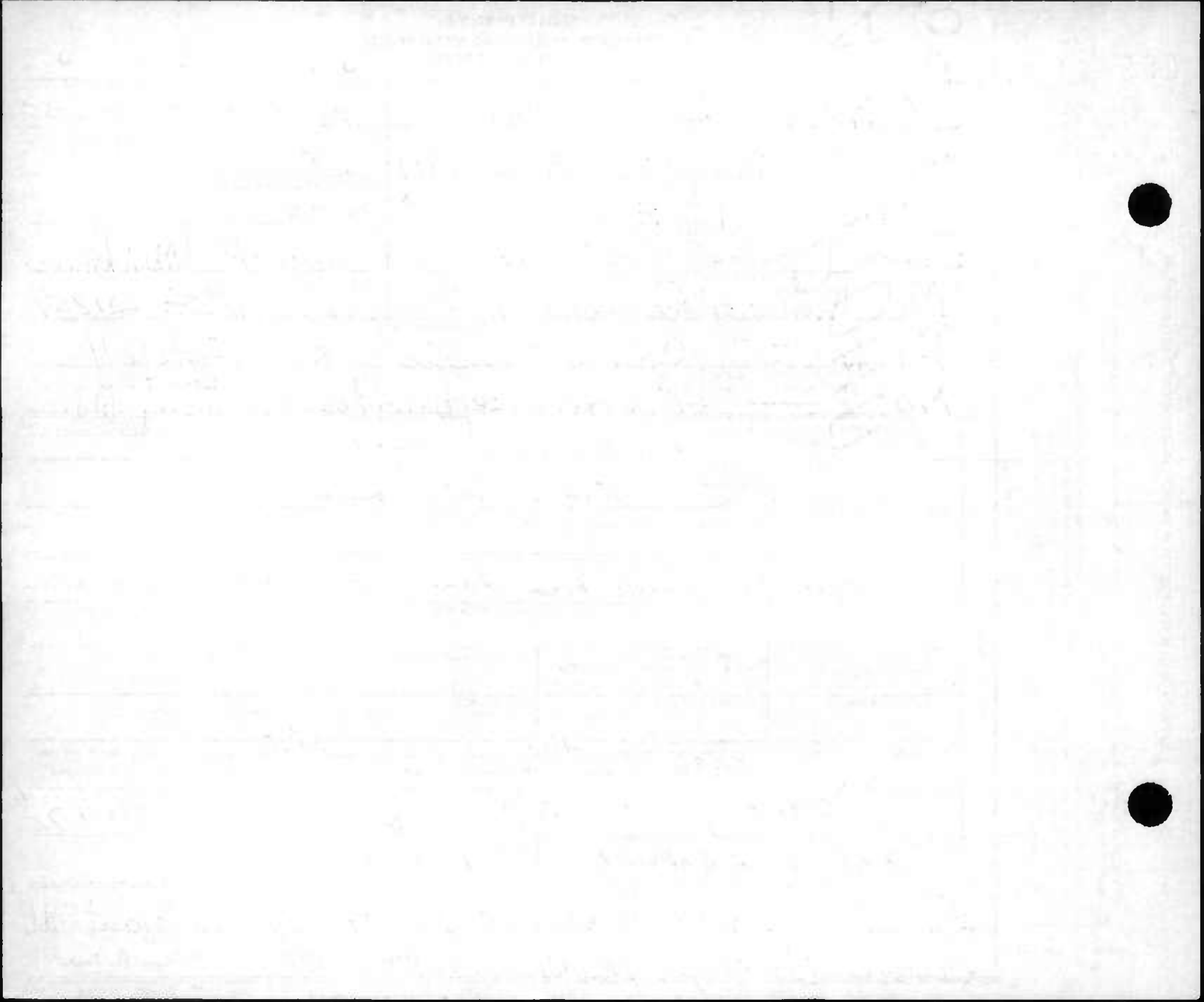
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 15510

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Chris L. Collier | | | 2a. DATE OF DEATH MONTH DAY YEAR May 30, 1987 | | 2b. HOUR 0255 M |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 3 3 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Maintenance |
| 13a. STATE Md. | | 13b. COUNTY Worcester | 13c. CITY OR TOWN Pocomoke | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Handy J. Collier | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie R. Satchell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 218-16-6681 | | 17. INFORMANT ADDRESS Josephine Press Pocomoke, Md. Rt. 3 Bx. 243 D | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ch atrial fib, anoxic brain damage, Acute Hepatitis, Ch alcoholism | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/30 , 19____, to 5/30 , 19____, that (I) (we) last saw the deceased alive on 5/29 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE BAL K A GARWAL | | DEGREE MD | | 22c. DATE SIGNED 5/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL K A GARWAL | | 22e. ADDRESS PGHMC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-6-87 | | 23c. NAME OF CEMETERY OR CREMATORY Dublin Bapt. Cem. | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Princess Anne Somerset Md. | | 23e. DATE REC'D. BY REGISTRAR JUN 3 1987 | | | |
| 24. FUNERAL DIRECTOR NAME Danuel G. Savage | | ADDRESS New Church, Va. | | 25. REGISTRAR'S SIGNATURE Frederick R. Rouse | |

BP



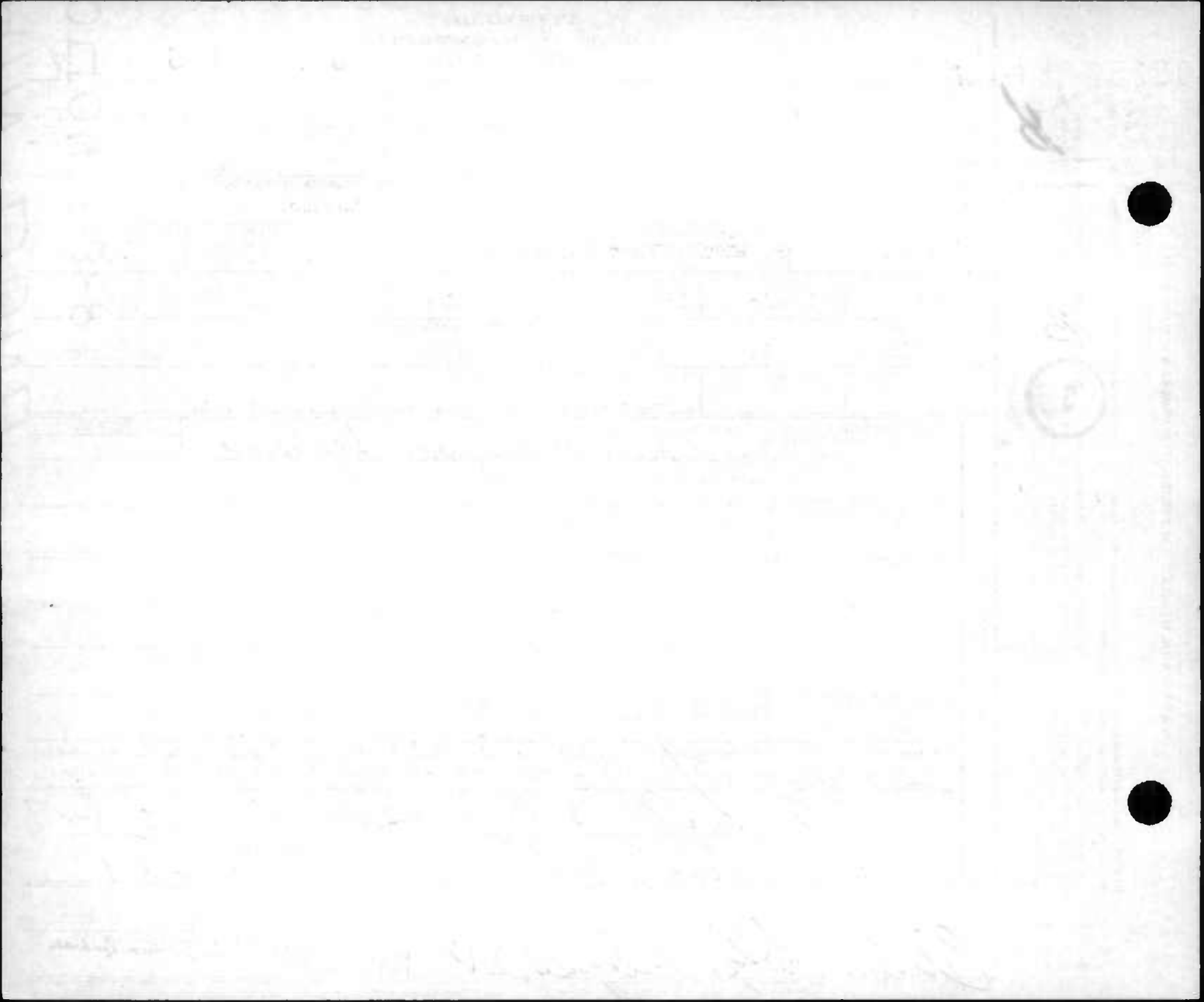
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15517
REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|--------------------|--|
| FOR 1. STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Patsy | | MIDDLE W. | | LAST COLLINS | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1987 | | 2b. HOUR 0715 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 13 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tech. Lab. | | 12b. KIND OF BUSINESS OR INDUSTRY Industrial | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Pittsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Rt. 346 Box 189 21850 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William P. Wilson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Watkinson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 229-66-6432 | | 17. INFORMANT George W. Collins, Pittsville, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/3 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If I (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>David E. Conall</i> | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-3-87 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David E. Conall, MD | | 22e. ADDRESS 145 E. Carroll St Salisbury, MD 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Willards Wicomico Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Charles W. Hodge, Selbyville, Del.</i> | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return it to the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IF DEATH OCCURRED IN A HOSPITAL, THE DEATH CERTIFICATE MUST BE NOTIFIED BY PHONE.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is essential that the death certificate be notified by phone.



053183 MAY 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15518

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES Randolph DAVIS | | | 7a. DATE OF DEATH MONTH DAY YEAR MAY 4, 1987 | | 7b. HOUR 0400 M |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 02 23 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pr. Anne, Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY Somerset | 13c. CITY OR TOWN Pr. Anne | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Littleton Davis | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Waters | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | 16b. SOCIAL SECURITY NO. 214-01-7946 | | 17. INFORMANT ADDRESS Ethel Davis Rt. 3 Box 371 E Pr. Anne | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock, cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. ad End stage renal failure ASHD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/3/87 to 5/4/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Constante J Tan | | DEGREE MD | | 22c. DATE SIGNED 5/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTE J TAN | | 22e. ADDRESS 547-D Riverside Dr. Salisbury, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/9/87 | 23c. NAME OF CEMETERY OR CREMATORY John Wesley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Anne Som. Md. |
| 24. FUNERAL DIRECTOR NAME William H. James III | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | |

MEDICAL CERTIFICATION

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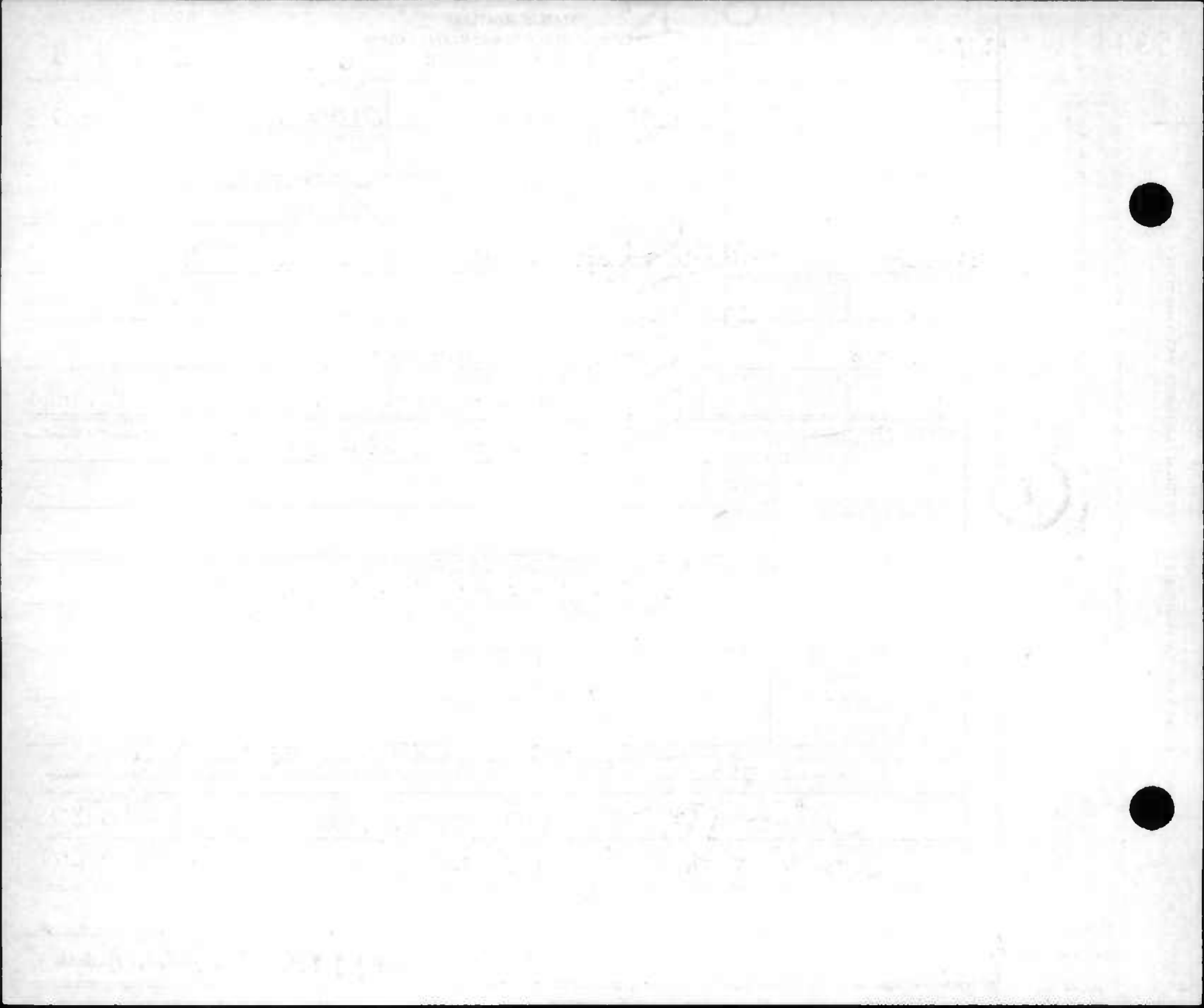
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15519

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin Phillip DAVIS | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 16 1987 | | 2b. HOUR 0840 ^{AM} |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR July 28, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm implements | 12b. KIND OF BUSINESS OR INDUSTRY farming | |
| 13a. STATE Maryland | 13b. COUNTY Worcester | 13c. CITY OR TOWN Berlin | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 17 S. Main St.. 21811 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Samuel Davis | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae Powell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 215 05 4871 | | 17. INFORMANT Mildred W. Davis 17 S. Main St. Berlin, Md. 21811 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 912 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Upper airway dysfunction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 6 month 10 years. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>A. Recurrent Aspiration. Diabetes.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>27 March</u> , 19 <u>87</u> , to <u>16 May</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>15 May</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <u>C. Rodney Layton, Jr.</u> | | DEGREE MD | | 22c. DATE SIGNED 5-16-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Rodney Layton, Jr. | | 22e. ADDRESS Carroll St. Peninsula Gen. Hospital Salisbury, Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | 23b. DATE 5/19/87 | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md. | |
| 24. FUNERAL DIRECTOR NAME W. Kirk Burbage | | 108 Williams St. Berlin, Md. 21811 | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1987 | 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u> |

BP

ORIGINAL
RECORDED
INDEXED



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5520

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | |
|---|-------------------------|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Willettt Darlington Denit | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 05 02 87 | | | 7b. HOUR 930 M a | | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 01 13 1912 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 75 | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD May 02 87 | | | 7d. HOUR 246 M p | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dist. Columbia | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | |
| 10. CITY OR TOWN OF DEATH Tyaskin | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O.Box 62, Tyaskin | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal-Consult. | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Int. | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Tyaskin | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS P.O.Box 62 21865 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Darlington Denit | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Skinner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 553-38-8822 | | 17. INFORMANT ADDRESS Ruth Denit (wife) Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Diabetes Mellitus, Lymphoma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas C Hill Jr | | | TITLE (SPECIFY) Deputy | | | MEDICAL EXAMINER | | | DATE SIGNED 5/02/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas C. Hill Jr. M.D. ADDRESS Pine Bluff Road, Salisbury, MD | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 5/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY Swansbury Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wic. Md | | |
| 24. FUNERAL DIRECTOR NAME Chapman | | | ADDRESS Blaug, Md. | | | 25a. DATE OF REGISTRATION MAY 7 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dinkens-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FV-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

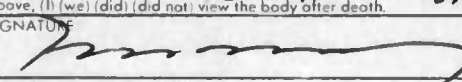
07/84
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BP
DHMH - 17
(VR A15 ME (5))

20% COTTON BLEND

054029 MAY 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15521
REG. NO.

| | | | | | | |
|--|--|---|---|---|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Augusta Dennard Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/14/87 | | 2b. HOUR MIN. 1:10 P.M. | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11-11-1914 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 72 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. RESIDENCE (IF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David DENNARD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel DENNARD | | | 13d. STREET ADDRESS / ZIP CODE 904 Park St - Salis-Md 21801 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 263-52-0830 | | 17. INFORMANT ADDRESS Elsie DENNARD 917A Park St. Salis-Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) CVA - Several. DUE TO, OR AS A CONSEQUENCE OF (c) ASVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 87 , to May 87 , that (I) (we) last saw the deceased alive on 5-14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE  | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/15/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. G. Arntner | | 22e. ADDRESS 3 Bay St Berlin 21811 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 5-18-87 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN ACRES | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD |
| 24. FUNERAL DIRECTOR NAME Clinton F. Stewart | | 25a. ADDRESS West Rd Salis-Md | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



The first thing I noticed when I stepped out of the car was the cold. It was a sharp contrast to the warm blanket I had been sitting under. I looked around and saw a few other people standing in the same way, looking at each other with expressions of surprise and curiosity. The air was thick with a strange, almost metallic scent that I had never before. I took a deep breath and felt a slight tingling in my lungs. The ground beneath my feet was uneven and seemed to shift slightly as I walked. I tried to focus on the task at hand, but my mind kept wandering to the strange sensations I was experiencing. The world around me felt like it was holding its breath, waiting for something to happen. I knew I was in a new place, a place where the rules of the universe might be different. I had to stay calm and figure out what was going on. The first step was to understand my surroundings. I looked at the people around me, trying to read their expressions. They all seemed to be in the same state of confusion. I knew I was not alone in this. The strange sensations were shared by everyone here. I had to find a way to communicate with them, to share what I was feeling. The first step was to listen. I closed my eyes and tried to hear the whispers of the universe. I felt a slight vibration in the air, a sound that was not quite a word but not quite a silence either. It was a sound that I had never heard before, a sound that felt like it was coming from the very heart of the world. I opened my eyes and looked at the people around me. They were all looking at me with expressions of surprise and curiosity. I knew I had just shared something with them, something that was not just a word but a feeling. I had taken the first step towards understanding this strange new world.

The second thing I noticed was the way the light felt. It was not just a simple illumination, but a presence. It seemed to be alive, moving and breathing. I looked up and saw a few stars in the sky, but they were not the stars I knew. They were different, more distant, more mysterious. I felt a slight pull towards them, a sense of longing that I had never before. I knew I was in a new place, a place where the rules of the universe might be different. I had to stay calm and figure out what was going on. The first step was to understand my surroundings. I looked at the people around me, trying to read their expressions. They all seemed to be in the same state of confusion. I knew I was not alone in this. The strange sensations were shared by everyone here. I had to find a way to communicate with them, to share what I was feeling. The first step was to listen. I closed my eyes and tried to hear the whispers of the universe. I felt a slight vibration in the air, a sound that was not quite a word but not quite a silence either. It was a sound that I had never heard before, a sound that felt like it was coming from the very heart of the world. I opened my eyes and looked at the people around me. They were all looking at me with expressions of surprise and curiosity. I knew I had just shared something with them, something that was not just a word but a feeling. I had taken the first step towards understanding this strange new world.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15522

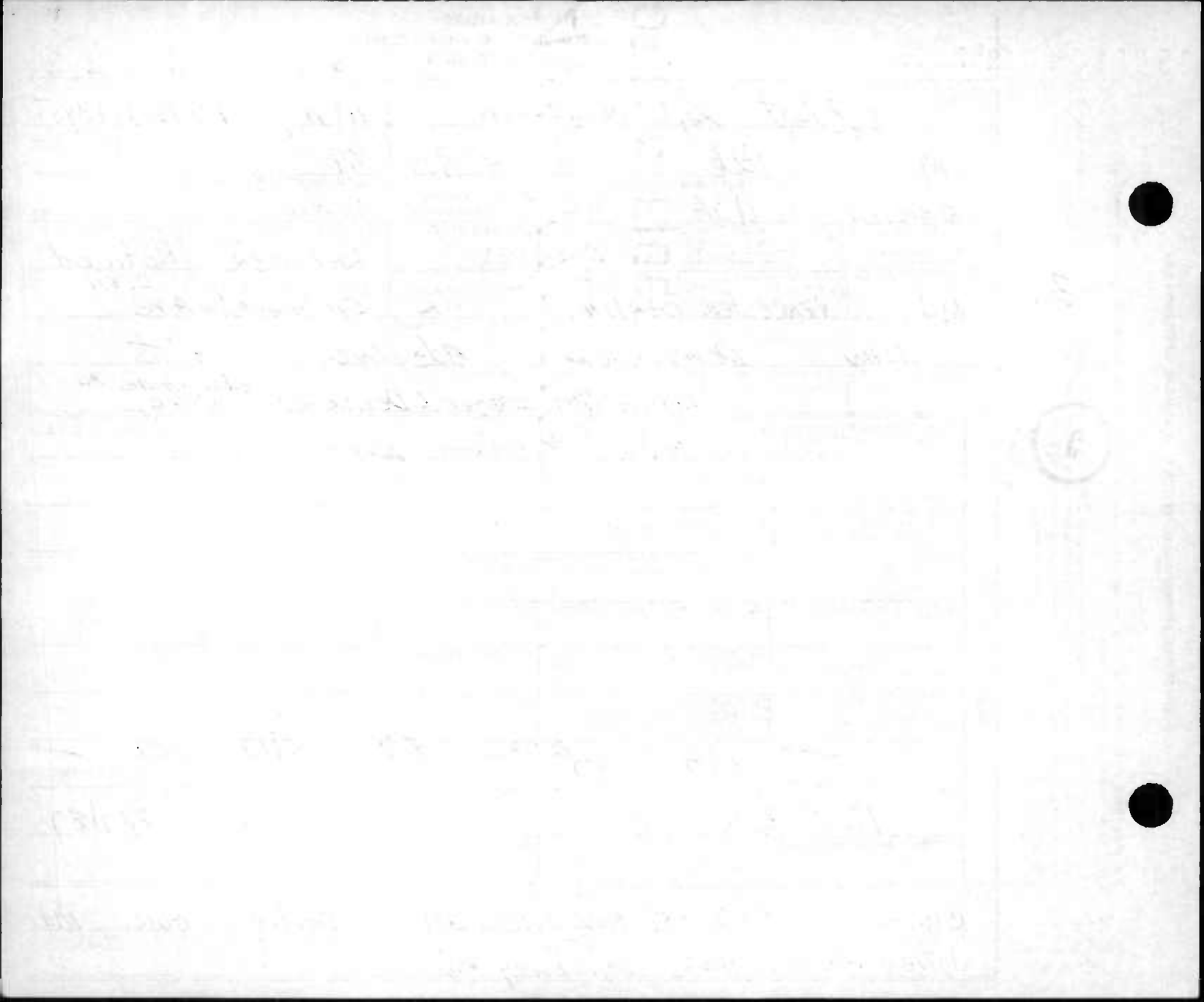
| | | | | | | | | |
|---|--|---|--|---|--|--|--|--------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Albert S. Perickson | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1987 | | | 2b. HOUR 1345 M | | |
| 3. SEX M | 4. RACE Blk | 5. DATE OF BIRTH MONTH DAY YEAR 3 5 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | | |
| 13a. STATE Md | | 13b. COUNTY Worcester | 13c. CITY OR TOWN Berlin | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 511 Franklin Ave 21811 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Derrickson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ade line Pitts | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | |
| 16b. SOCIAL SECURITY NO. 314-12-5769 | | 17. INFORMANT Esther L. Perickson | | ADDRESS Add. Same as Above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic heart DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/17 , 19 87 , to 5/17 , 19 87 , that (I) (we) saw the deceased alive on 6/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE M. J. Horen MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/17/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY New Bethel UM | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worc. Md. | | |
| 24. FUNERAL DIRECTOR NAME Jolley Mem. Chapel | | ADDRESS RT 2 Salisbury Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Kendall | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the "Important" pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified of cause.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

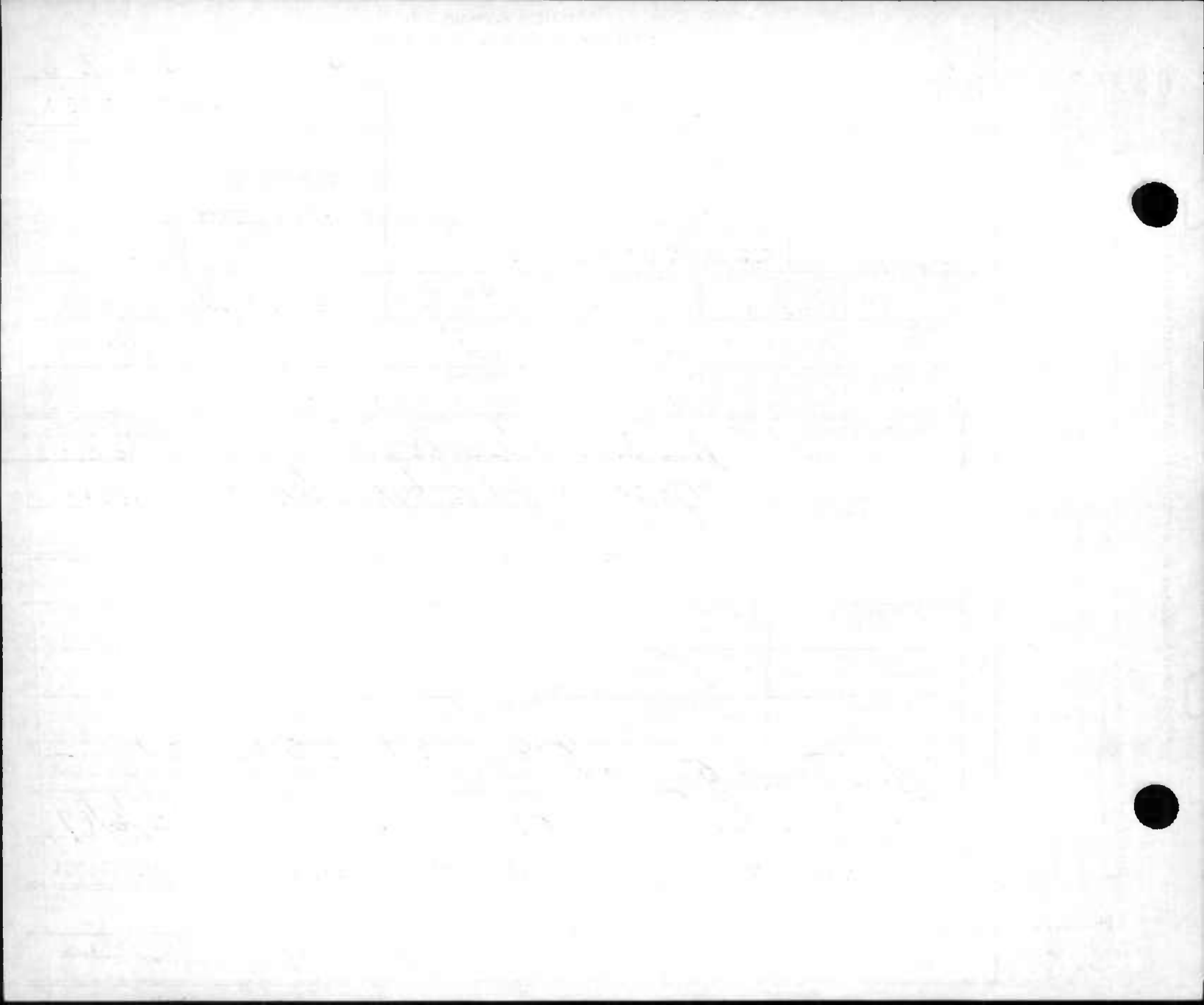
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15523



| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST NINO R. DEWEY | | 2a. DATE OF DEATH MONTH DAY YEAR 5-6-87 | | 2b. HOUR 1:05 A ^M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 10 1893 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 93 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Bakery | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Otis W. Dewey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Guild | | 13e. STREET ADDRESS / ZIP CODE Box 212 Old O.C. Road 21801 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT Alma Ruth Dewey | | ADDRESS Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>gms.</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4-8</u> 19 <u>87</u> , to <u>5-6</u> 19 <u>87</u> , that (I) (the hospital) saw the deceased alive on <u>5-6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE <i>Earl M. Beardsley</i> | | | | DEGREE MD | | 22c. DATE SIGNED 5/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | | | 22e. ADDRESS CIVIC AVE & RT. 50, SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-8-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Ga. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wicomico MD | |
| 24. FUNERAL DIRECTOR BAKER AND BOUNDS | | | | ADDRESS SALISBURY, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR MAY 08 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Randall</i> | | | |



054526 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5524

| | | | | | | | | |
|--|-----------------|--|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Donald Dickson | | | 2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 20 1987 | | | 2b. HOUR 9:12A | | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 25, 1940 | 6 AGE (IN YEARS) LAST BIRTHDAY 46 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 5 20 1987 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker/Building | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Whiton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS P.O. Box 309 Berlin, MD 21811 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Milton Dickson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Hadder | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 40 2542 | | 17. INFORMANT St. Martins Berlin, Maryland 21811 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | | TITLE (SPECIFY) M.D. Assistant | | | DATE 5-20-87 SIGNED | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin, Worcester, Maryland | | |
| 24. FUNERAL DIRECTOR NAME W. Kirk Burbage | | | | 108 Williams St. Berlin, MD 21811 | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1987 | | 25b. REGISTRAR'S SIGNATURE  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

REPT. 10-27-1933

CHICKAWA C. 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 above injury, or other traumatic event, the medical examiner must be notified at once.

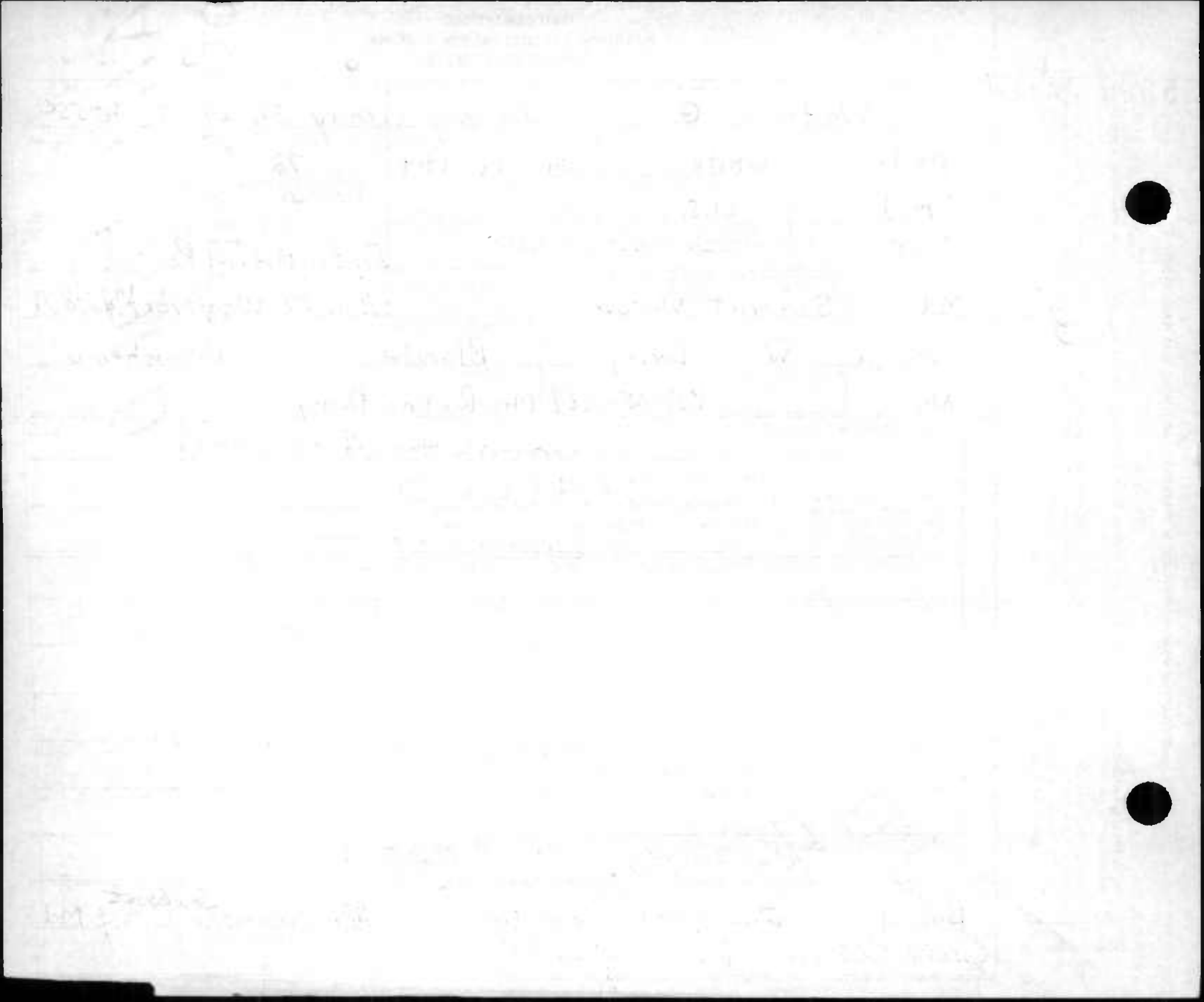
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15525

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter G. Dorsey | | | 2a. DATE OF DEATH MONTH DAY YEAR May 31, 1987 | | | 2b. HOUR 0550 M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 19 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | 12a. USUAL OCCUPATION Dept of Natural Res. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Westover | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W. Dorsey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Beauchamp | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-05-7669 | | 17. INFORMANT Mrs Pauline Dorsey | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) HASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1c | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20 1987 to 5/31 1987, that (I) (we) last saw the deceased alive on 5/30 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. L. Raffetto | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Raffetto | | | 22e. ADDRESS PGH | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF BY) Burial | | | 23b. DATE June 3 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Quentin | | 23d. LOCATION RFD Pocomoke City Md | | |
| 24. FUNERAL DIRECTOR NAME James L. Henman | | | ADDRESS Pocomoke Md | | | 25a. DATE JUN 5 1987 | | | |

JUN 5 1987
REGISTRAR'S SIGNATURE
J. L. Raffetto



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 15520

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul P. DURHAM | | 2a. DATE OF DEATH MONTH DAY YEAR May 1, 1987 | | 2b. HOUR 5:40 M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 6/23/18 MONTH DAY YEAR 06-28-18 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Durham | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Savannah Outten | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sup. Public Works | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 212-16-1763 | | 17. INFORMANT ADDRESS route 2, box 243 Pocomoke City, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.C.V.D DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 87 to 5/1 19 87 that (I/we) saw the deceased alive on 5/1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Inja J. Hwang | | DEGREE M.D. | | 22c. DATE SIGNED 5/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D. | | 22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem. Pocomoke Worcester Md. | |
| 24. FUNERAL DIRECTOR Scott S. Melsan | | ADDRESS Pocomoke City, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 06 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

May 1, 1961

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8715527

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy V. Elliott | | | 2a. DATE OF DEATH MONTH DAY YEAR May 11 1987 | | | 2b. HOUR 1:50 P. M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 07 25 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mardela, Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Mardela Springs | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Bridge Street 21837 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Graham | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gillis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | |
| 16b. SOCIAL SECURITY NO. 213-01-1300 | | 17. INFORMANT Elizabeth Elliott Parsons (Daughter) Bridge St., P.O. Box 56, Mardela Springs, Md. 21837 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinson's disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>Dec. 12</u> , 19 <u>83</u> , to <u>May 11</u> , 19 <u>87</u> , that <u>X</u> (we) last saw the deceased alive on <u>May 11</u> , 19 <u>87</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>X</u> (we) did <u>XX</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>M. Shrestha</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5.11.87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Shrestha, M.D.</u> | | | | 22e. ADDRESS <u>Post Office Box 2018, Salisbury, MD 21801</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>5/14/1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mardela Memorial Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Mardela, Wicomico, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Holloway Funeral Home, P.A., Salisbury, Maryland</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 15 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

United States : 1900

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054924 JUN

Items, 18a. & 22a., G-62B, by Med. Exam. STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

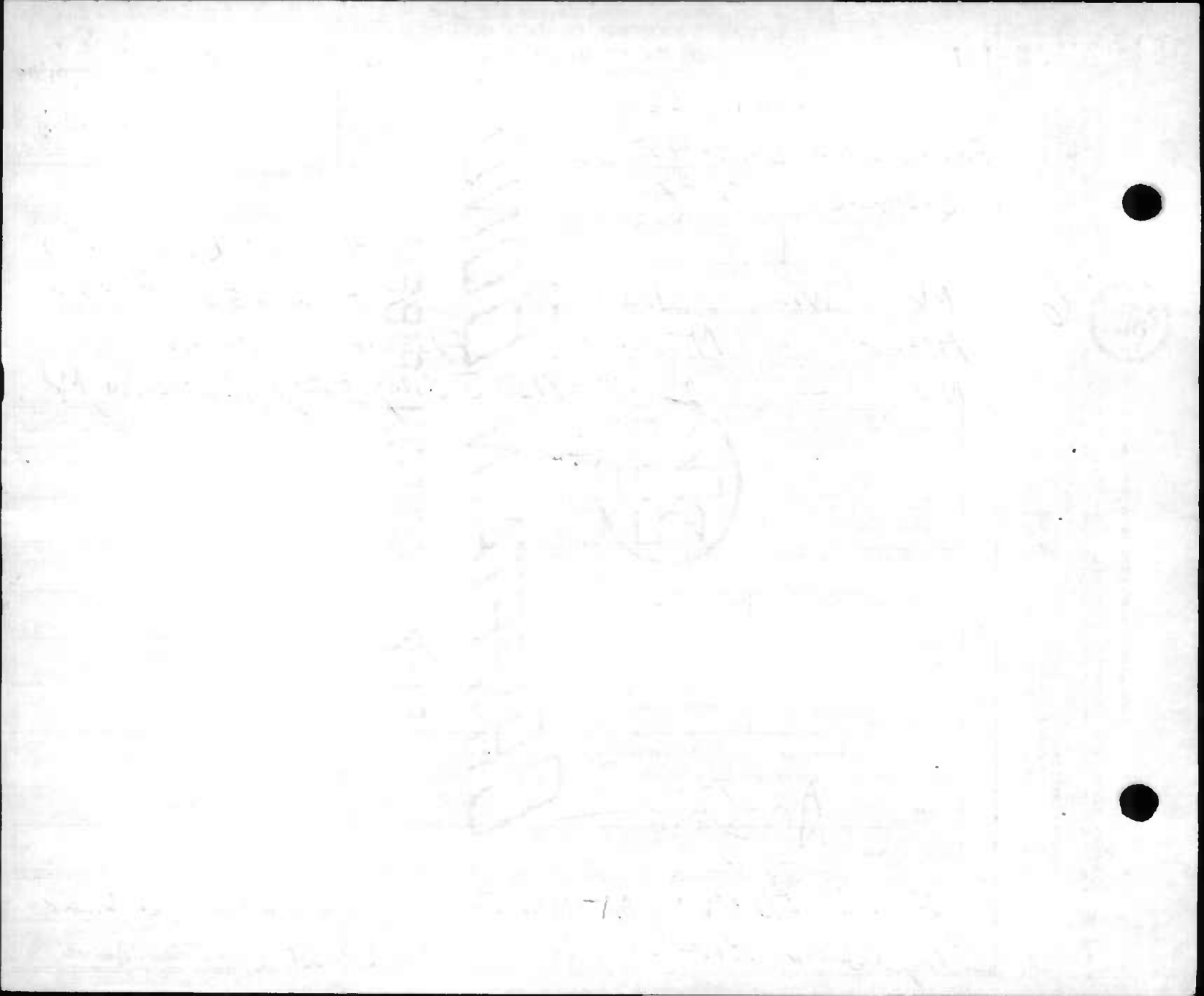
15528
REG. NO.

| | | | | | | | | | |
|--|------------------------------|--|---|-------------------------|---|--------------------------|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Margie Lee ELSEY | | | | 5-22-87 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Black | 4-15-1935 | 52 YRS. | | | 5-22-87 | | 4:30AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Delaware | V.5A. | | | | Wicomico County MD. | | | | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Nanticoke | | Hickman Lane | | | Teacher's Assistant | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Md | | Wic | Nanticoke | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | P.O. Box 53 | | 21840 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Alfred Mitchell | | | Flossie Allen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 220-32-8123 | | J. Riley Elsey, Nanticoke, Md | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a). Hypertensive cardiovascular disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | |
| (b). DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c). | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | |
| | | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | DATE SIGNED | |
| Ann M. Dixon, M.D. | | | Deputy Chief | | | | | 5-22-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | |
| Ann M. Dixon, M.D. | | | 111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | | 5/26/87 | | Mt Nebo Cem. | | Columbia, Delaware | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| C. J. Pessink, Brandywine, Md | | | | | MAY 28 1987 | | Julia Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN MORRIS FLETCHER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 26, 1987 | | | | | 2b. HOUR P 2:15 | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 7, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH SHARPTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 RAILWAY STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEERING ASS'T | | | 12b. KIND OF BUSINESS OR INDUSTRY PUBLIC UTILITY | | | |
| 13a. STATE MD | | | | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN SHARPTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 600 RAILWAY STREET/21861 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HOMER FLETCHER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERONA MORRIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT P.O. BOX 156 AUDREY F. FLETCHER, SHARPTOWN, MD 21861 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bulbar paralysis cerebral thrombosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>1 year ±</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> 19 <u>87</u> to <u>death</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Ernest Larmore</u> | | | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/30/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E M. LARMORE | | | | | 22e. ADDRESS Delmar Re | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 5-29-87 | | 23c. NAME OF CEMETERY OR CREMATORY SPRINGHILL MEM. GARDENS | | | 23d. LOCATION CITY OR TOWN COUNTY STATE HEBRON WICOMICO MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, SHARPTOWN, MD 21861 | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 8 1987 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

2/3/11

2. M. Chubb
100
2/17 23/11

2. M. Chubb
100
2/17 23/11

054295 MAY 22 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, and local examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15530
REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William LEVIN Fooks | | | 2a. DATE OF DEATH MONTH DAY YEAR May 8 1987 | | 2b. HOUR 1500 M |
| 3. SEX MALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 4 3 19 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS HOURS MIN. | | IF UNDER 1 YEAR IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WORCESTER 13c. CITY OR TOWN BERLIN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Will Fooks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY DAVIS | | 13e. STREET ADDRESS / ZIP CODE Route #2, Box 67/21811 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | 17. INFORMANT ANNE MAE Fooks | | ADDRESS SAME AS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> 19 <u>87</u> , to <u>5/8</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>4/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Ronald H. Jones</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/8/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD H. JONES | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE <u>5-22-87</u> | 23c. NAME OF CEMETERY OR CREMATORY Evergreen | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin - <u>Wicomico</u> Md. | | |
| 24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel | | ADDRESS Rt # 2 Salisbury, Md. | | 25. DATE REC'D. BY REGISTRAR MAY 21 1987 | |

MEDICAL CERTIFICATION

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

(P)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The permit is to be filed with the State Dept. of Health and Mental Hygiene for removal, cremation, or removal.

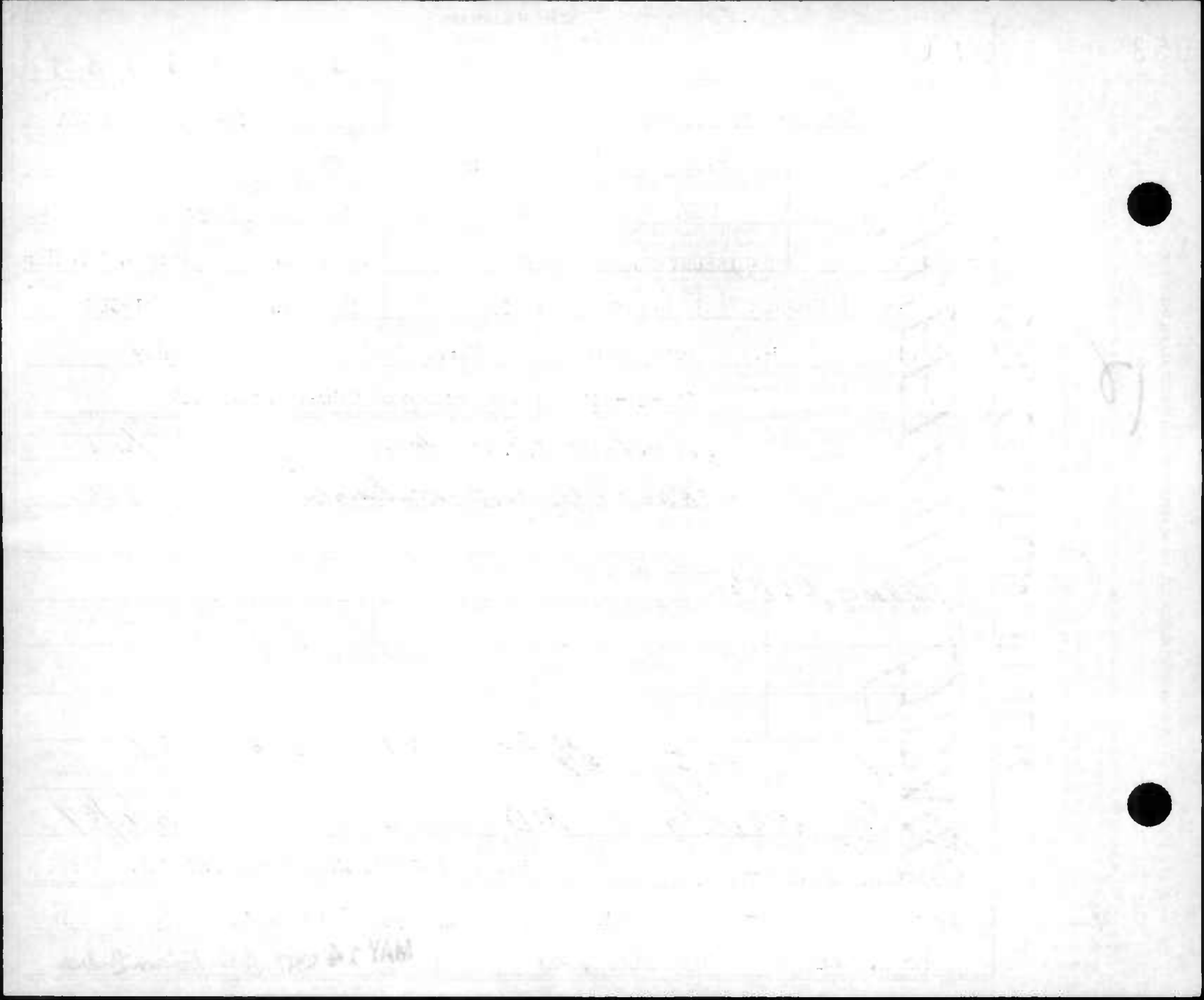
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

OHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|---|--|--|
| FOR STATE REGISTRAR | | 87 | | REG. NO. 15531 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GILBERT FREDERICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-6-87 | | 2b. HOUR 9:30A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 29 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD | |
| 10. CITY OR TOWN OF DEATH SALISBURY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY steam & boiler |
| 13a. STATE Delaware | | 13b. COUNTY Sussex | 13c. CITY OR TOWN Laurel | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE Box 270 19956 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis H. Frederick | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Haley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 182-07-5106 | | 17. INFORMANT ADDRESS The Estate of Gilbert Frederick | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: previous CVD's. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 5-5-87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE RT. 50 & CIVIC AVE, SALISBURY, MD. 21801 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-5-87 to 5-6-87 that (I) (we) lost saw the deceased alive on 5-5-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (How) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Earl M. Beardsley | | DEGREE MD | | 22c. DATE SIGNED 5/6/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | 22e. ADDRESS RT. 50 & CIVIC AVE, SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5-8-87 | 23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Centreville QA MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John E. Boulais Greensboro, MD | | 25a. DATE REC'D. BY REGISTRAR MAY 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Sanders-Rodden | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 60M 7/84
(VRA 15, 4)

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 87 REG. NO. 15532 | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Gale</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5-7-87</i> | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12-16-42</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>44</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dunsthed Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Md.</i> | | 13b. CITY OR TOWN <i>Salisbury</i> | | 13c. STREET ADDRESS / ZIP CODE <i>222 CATHERINE ST. Md. 21801</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>CLIFTON GALE</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MAMIE DASHIELL</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>212-40-7695</i> | | 17. INFORMANT ADDRESS <i>MAMIE DASHIELL 222 CATHERINE ST. Md. SALIS</i> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AIDS related Complex</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-16</i> 19 <i>87</i> to <i>5-7</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>5-7</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Elsa M. Goris M.D.</i> | | | | DEGREE <i>M.D.</i> | | 22c. DATE SIGNED <i>5-7-87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Elsa M. Goris</i> | | | | 22e. ADDRESS <i>Dunsthed Center Salisbury Md. 21801</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>05/08/1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Salisbury Crematory</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury, Wicomico, Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Clinton F. Stewart Funeral Home, Salisbury, Maryland</i> | | | | 25a. DATE RECD BY REG. CLERK MAY 19 1987 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 17. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | Ann Gary | | | | May 13, 1987 | | 30 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | Blk | | 4 29 15 | | 72 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | |
| Manning S.C. | | U.S.A. | | | | Wicomico County | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Deer's Head Center | | Factory Worker | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| MD. | | Wico. | | Salisbury | | | | 1111 West Rd. Salisbury 21801 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Alfred Brand | | Loveria Burgess Brand | | | | 248-64-7690 | | Willie Gary 903 H Booth Street - Salisbury | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of cervix - abdominal metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>87</u> , to <u>5/13</u> , 19 <u>87</u> , that (I/we) lost saw the deceased alive on <u>5/13</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Inja J. Hwang | | | | | | 5/13/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Inja J. Hwang, M.D. | | Deer's Head Center, Salisbury, MD. 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 5-17-87 | | Springhill Memory Garden | | Arlon Wico. MD. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| La. Watson - owner | | West Rd. | | MAY 19 1987 | | Julia Davidson-Randall | | | |
| A.E. Ward F/H Salisbury, Md. 21801 | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

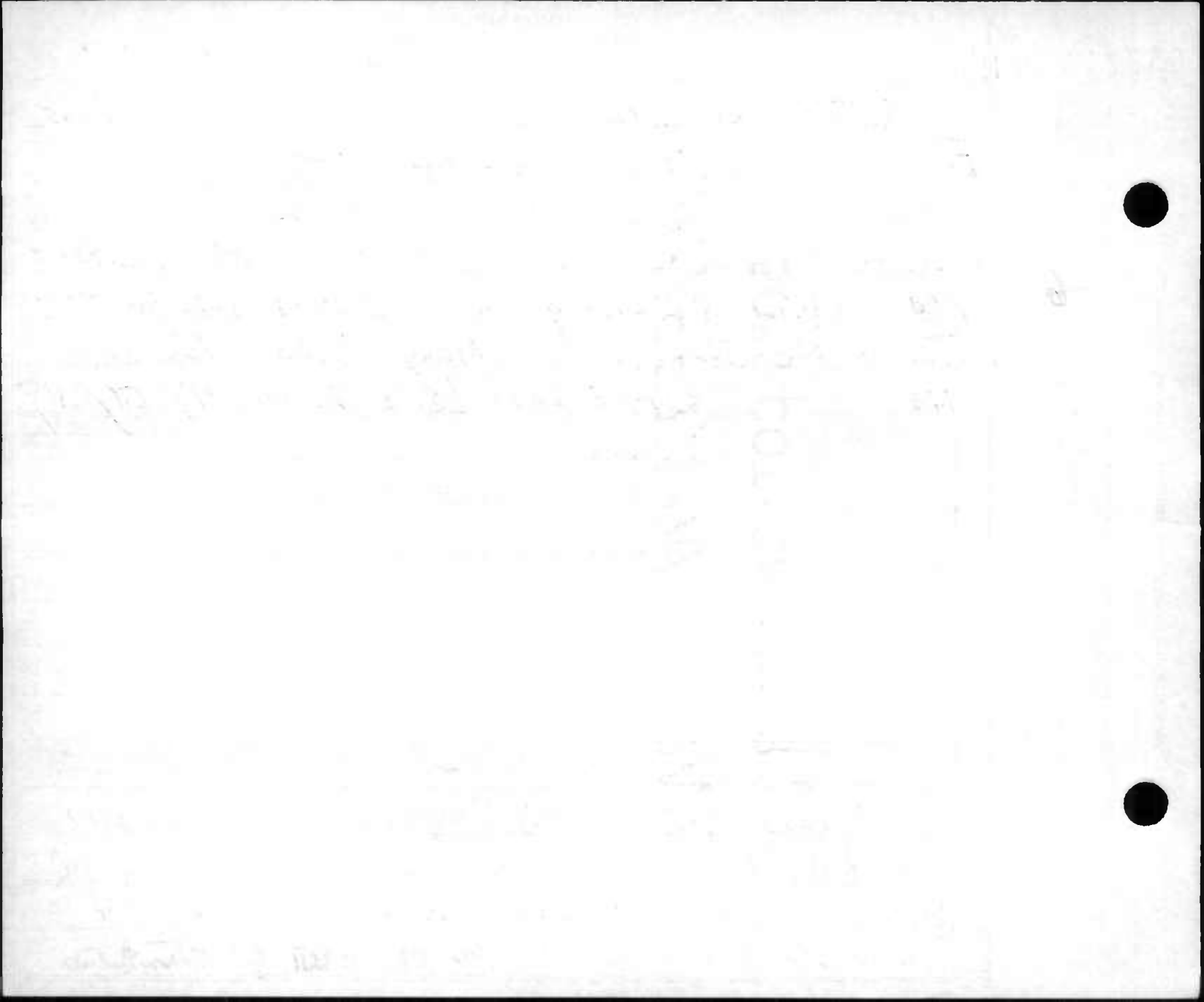
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Katie Priscilla Gates | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 5, 1987 | | 2b. HOUR 0045 M | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7-14-1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 13a. STATE MD | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 1109 Mineola Ave. 21801 | | 14. FATHER'S NAME FIRST MIDDLE LAST James H. Jones, Sr. | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 14b. SOCIAL SECURITY NO. 921-05-2801 | | 14c. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Delia Turner | |
| 15. ADDRESS 161 1/2 Chestnut, N.Y. City, N.Y. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 87 , to 5/5 , 19 87 , that (I) (we) lost saw the deceased alive on 5/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph A. Grasso | | DEGREE MD | | 22c. DATE SIGNED 5/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | 22e. ADDRESS 145 E Carroll St Salisbury MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Hd of Cecil Cem. Annapolis, MD | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Cornelius J. Messing, Biville, MD | | | |
| 25a. DATE REC'D BY REGISTRAR MAY 8 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Rodgers | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15535

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TRUMAN R. GOCHNOUR | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 04 1987 | | | 2b. HOUR 6:00 P M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov 9, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 13a. STATE Md | | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Manakin | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hiram Gochneur | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia McClewen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-12-4449 | | 17. INFORMANT ADDRESS Kennard Gochneur Po Box 35 Manakin, Md 21836 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>previous CVA's - ASCVD</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>0-19</u> 19 <u>87</u> , to <u>5-4</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If available, (I) (we) did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE Earl M. Beardsley M.D. | | | | DEGREE M.D. | | 22c. ADDRESS Civic Ave & Route 50, Salisbury, MD 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial | | | | 23b. DATE May 7, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Beachwood | |
| 24. FUNERAL DIRECTOR NAME James L. Hinman Jr | | | | ADDRESS Pr Anne, Md 21853 | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

054525 MAY 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5536

| | | | | | | | | | | | | | | | | | | | | | |
|---|---------|------------------------------------|--|-------------------------------|--|---|--|--------------------------|---|--|----------------|-----------------------------------|--|-------------------|--|---|--|---------------------|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | HOUR | | | | | | | | | |
| Loretta C. Gordy | | | | | | 5 19 87 | | | 1618 | | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) (LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | HOUR | | | | | | | |
| Female | White | 6 25 10 | 76 YRS. | | | | | 5 19 87 | | | 1618 | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| VIRGINIA | | | USA | | | | | | Wicomico MD | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Salisbury | | | Peninsula General Hospital | | | | | | Seamstress | | | Clothing | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | 13f. CITY OR TOWN | |
| Maryland | | | | | | | | | | | | Worcester | | Berlin | | YES | | 3 Washington St. | | Berlin, MD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | ADDRESS | | | | | | | | | |
| Archie Cropper | | | | | | Ida L. Nock | | | | | | Rt. 1, Box 87 A | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | | | | |
| NO | | | | | | 214 10 6435 | | | | | | Shirley L. McDonald | | | | | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE John T. Bulkeley M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 5-19-87
EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D. ADDRESS Salisbury, Maryland

| | | | | | | | |
|---|--|--------------------------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 5/22/87 | | Springhill Memory Gardens | | Salisbury, Wicomico, MD | |
| 24. FUNERAL DIRECTOR NAME | | 108 Williams Street ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| W. Kirk Burbage | | Berlin, Maryland | | 21811 | | MAY 25 1987 <u>Julia Anderson-Kendall</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25MDHMH - 17
(VR A15 ME (5))

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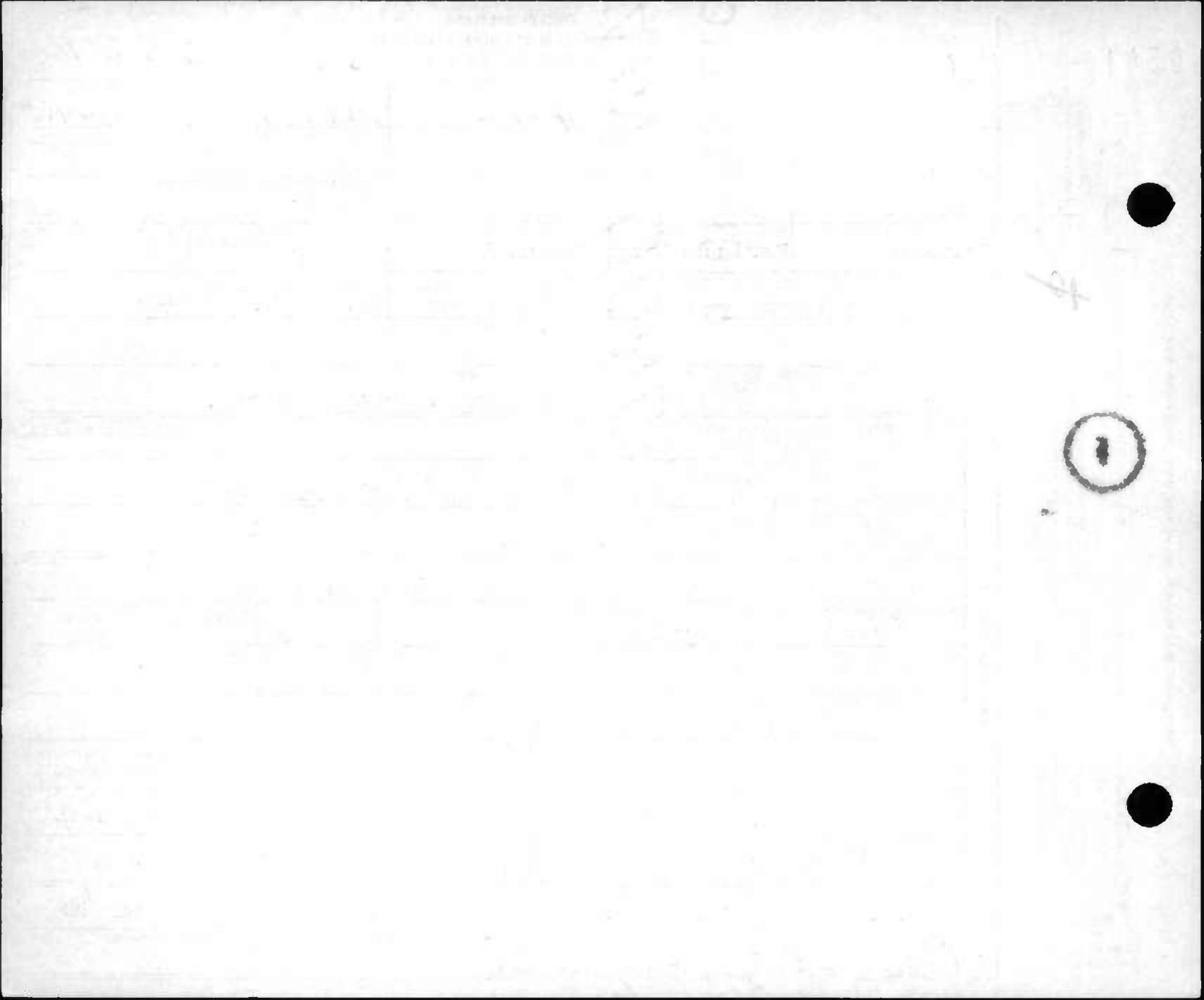
10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert certificate in pages 1 and 2 and have them filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--------------------------------|---|--|
| <div style="text-align: right;">REG. NO. 87 15537</div> | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arlanta E. HALL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 17, 1987 | | 2b. HOUR 0448 ^{AM} | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 2 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Delaware | | 13b. COUNTY Sussex | | 13c. CITY OR TOWN Selbyville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 70 19975 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Rodney | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Gray | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 722-16-0079 | | 17. INFORMANT ADDRESS Demmy O. Merritt, Dagsboro, DE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable separation of bowel</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36-48h 36-48h 36-48h |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>END stage liver disease, Chronic Active hepatitis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION 5/10/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/16/87</u> , 19 <u>87</u> , to <u>5/17/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/17/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Steven L. Crawshaw MD | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRAWSHAW | | | | 22e. ADDRESS 145 E. CARROLL ST. SALISBURY | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 19, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Bishopville | | 23d. LOCATION CITY OR TOWN COUNTY Bishopville Worcester MD | | | |
| 24. FUNERAL DIRECTOR Charles W. Hartz, Selbyville, Del. | | | | 25a. DATE OF REGISTRATION MAY 19 1987 | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked other than (1) above, injury, or other traumatic event, the medical officer of the coroner must be notified of same.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Hartman | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 30 1987 | | 2b. HOUR 0650M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 07 03 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Businessman | | 12b. KIND OF BUSINESS OR INDUSTRY Investment | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Wicomico 13c CITY OR TOWN Salisbury | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1205 Taney Avenue 21801 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hartman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Garfinkel | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 100-12-5089 | | 17. INFORMANT Louise B. Hartman (Wife) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction in</u> DUE TO, OR AS A CONSEQUENCE OF <u>relapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>5/28</u> , 19 <u>87</u> , to <u>5/30</u> , 19 <u>87</u> , that (1) <u>was</u> lost saw the deceased alive on <u>5/30</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (2) <u>was</u> (did) <u>not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph D. Grasso</u> | | | | | DEGREE <u>MD</u> | | | 22c. DATE SIGNED 5/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph D. Grasso</u> | | | | | 22e. ADDRESS <u>135 E. Camell St Salisbury MD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 05/31/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland | | | |
| 24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1987 | | 25b. REGISTRAR'S SIGNATURE <u>John F. ...</u> | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, it must be notified to the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WALLACE H. HEARNE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 21 1987 | | | | | 2b. HOUR 2 P M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3-15-24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRAINER | | 12b. KIND OF BUSINESS OR INDUSTRY NORSE | | | |
| 13a. STATE MD | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN WIMBLESVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE RR 1 21872 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. NEGRN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGIE CLARK | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 26-16-7340 | | 12. INFORMANT ADDRESS D. WILKINS PITTSBURGH, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid bleeding DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 87 , to 5/21 19 87 , that (I) (we) last saw the deceased alive on 5/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE E. Lignos | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-21-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVANGELDS C. LIGNOS | | | | 22e. ADDRESS MED. CENTER N. #6, SALISBURY | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 5/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY SALISBURY CR | | 23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY WIC MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME ULRICH F.H. BERLIN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

X

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the purchase of the book of the title mentioned therein. I am sorry to hear that the book is not available at the time. I will endeavor to locate a copy for you as soon as possible.

Yours truly,
[Signature]

I am, Sir, very respectfully,
Your obedient servant,
[Signature]

053411 MAY 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

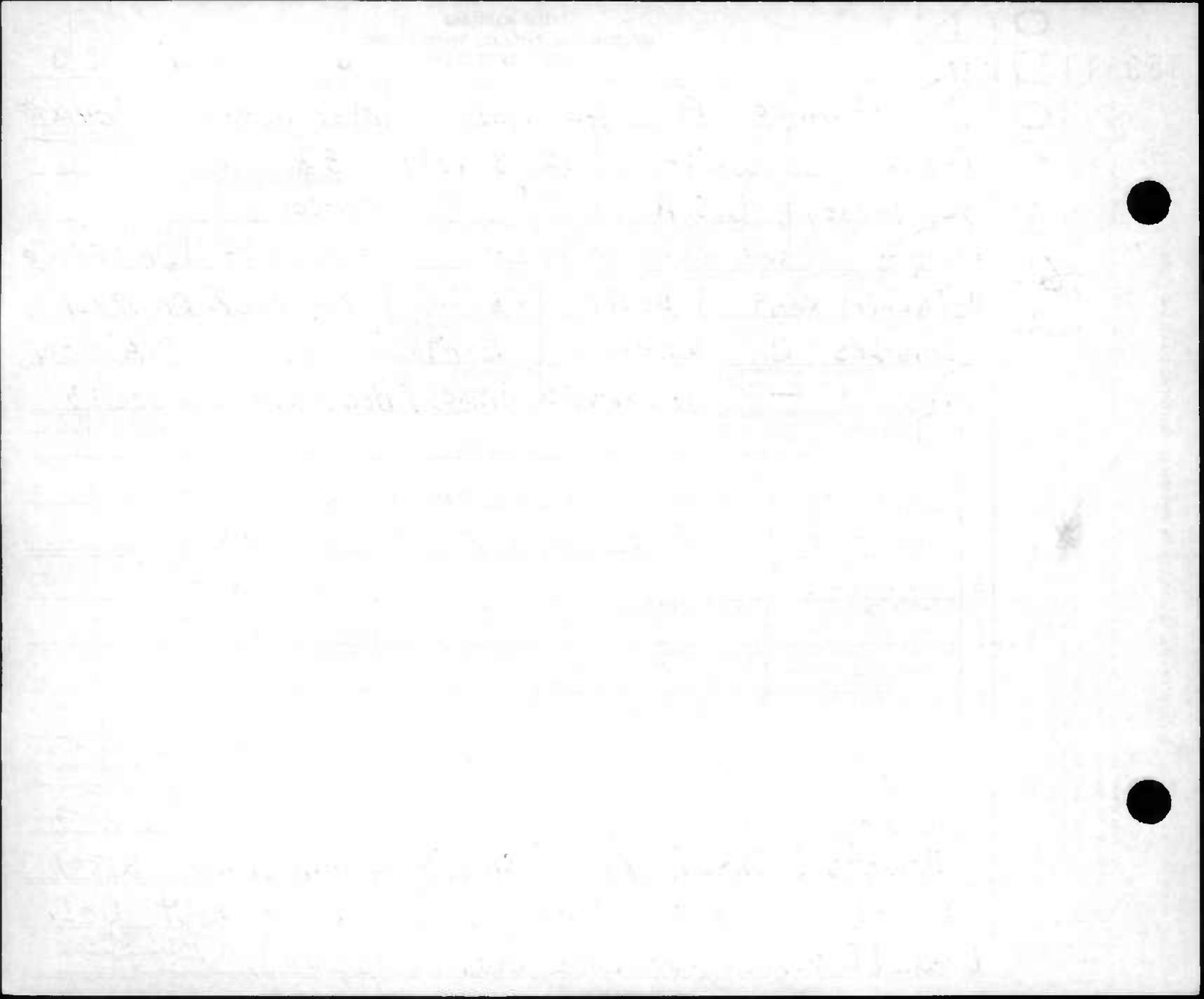
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15540

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELAINE F. HENNESSY | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1987 | | 2b. HOUR 0415^{MT} | |
| 3. SEX FEMALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 3 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptist | | 12b. KIND OF BUSINESS OR INDUSTRY Dr. Office |
| 13a. STATE DELAWARE | | 13b. COUNTY Kent | 13c. CITY OR TOWN Dover | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles J. Wheelen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Letaude F. Madsen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 142-26-6635 | | 17. INFORMANT ADDRESS JAMES P. Hennessy See Sec 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ELECTRICAL - MECHANICAL DISSOCIATION DUE TO, OR AS A CONSEQUENCE OF (c) HEART FAILURE - ASCVD & CAD | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 5-11 , 19 87 , to 5-17 , 19 87 , that (I/we) last saw the deceased alive on 5-11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dennis J. Chodnicki M.D. | | | | 22c. DATE SIGNED 5/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis J. Chodnicki | | | | 22e. ADDRESS Salisbury, Maryland 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/14/1987 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Dover Kent Del. | | 24. FUNERAL DIRECTOR NAME ADDRESS Baker & Bounals Salisbury, Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 13 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dindon-Rodgers | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be mailed to the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15541

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beatrice J. Howard | | 2a. DATE OF DEATH MONTH DAY YEAR 5-4-1987 | | 2b. HOUR M AM | |
| 3 SEX FEMALE | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12-23-1915 | |
| 6 AGE (IN YEARS (LAST BIRTHDAY)) 71 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 714 Olivia Street | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13a. STREET ADDRESS / ZIP CODE 714 Olivia St. Salisbury MD 21801 | | 14. FATHER'S NAME FIRST MIDDLE LAST Johnnie Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia Jones | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-14-4362 | | 17. INFORMANT NAME ADDRESS Esther Nichols 404B Brackledge Dr. Salisbury MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) HAS CVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN YES | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Past CHF, L.B.B.B. & Recent onset. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7-87 to 3-87 , that (I) (we) lost saw the deceased alive on 3-7-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE F. W. COLLIGAN | | DEGREE MD | | 22c. DATE SIGNED 5/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. COLLIGAN | | 22e. ADDRESS 540 RIVERSIDE DR. SALISBURY MD 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-9-87 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Gardens | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wicco Md | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1987 | | 25b. REGISTRAR'S SIGNATURE John R. Randall | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Caladys Stewart West Rd Salis. Md | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

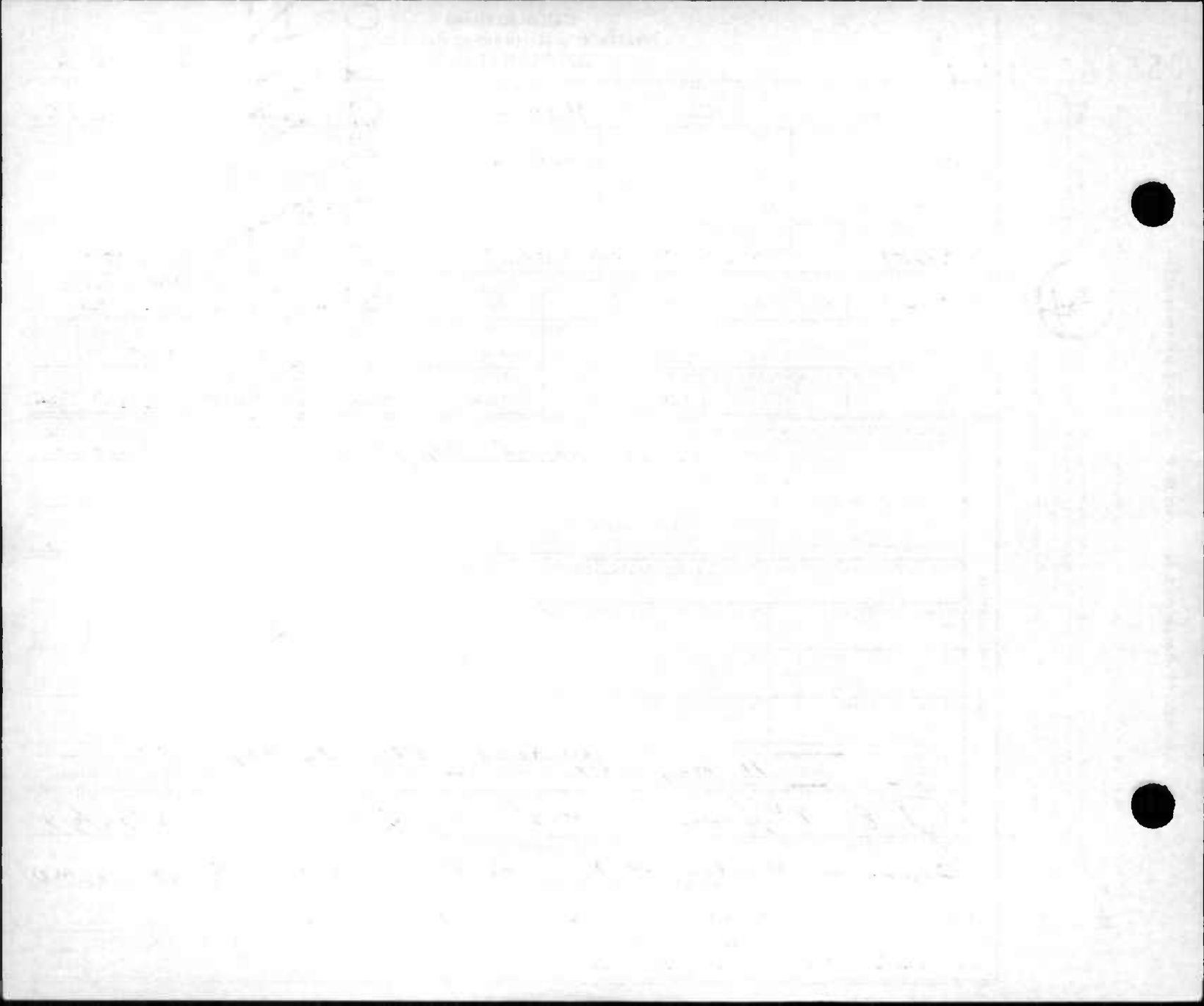
IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15542

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOLORES ANN HUDSON | | 2a. DATE OF DEATH MONTH DAY YEAR May 28, 1987 | | 2b. HOUR 0930 ^{AM} | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR August 24, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore City | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Worcester Ocean City | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE Box 292 H Bonita Dr. 21842 MD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Luby | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marlatt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216 20 6780 | | 17. INFORMANT Box 292 H Dennard L. Hudson, Jr. Ocean City, MD 21842 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>30 April</u> , 19 <u>87</u> , to <u>28 May</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11 May</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>J. E. Martin</u> | | DEGREE M.O. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Martin, M.O. | | 22e. ADDRESS 145 E. Carroll St., Salisbury, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Episcopal | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin, Worcester MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. Kirk Burbage Berlin, MD 21811 | | 25a. DATE REC'D. BY REGISTRAR JUN 3 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DELLA JOHNS JACKSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 11, 1987 | | 2b. HOUR 0023 A | | |
| 3. SEX F | | 4. RACE BLK. | | 5. DATE OF BIRTH MONTH DAY YEAR 8 23 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIENNA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY House Keeper | |
| 13a. STATE MD | | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN VIENNA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Johns | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Aurelia Collins | | | 16. STREET ADDRESS / ZIP CODE Route #1, Box 25 21869 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO | | 16b. SOCIAL SECURITY NO. 220-10-6359 | | 17. INFORMANT Odessa FARRARA | | ADDRESS SAME AS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) E Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) P DUE TO, OR AS A CONSEQUENCE OF (c) P | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | | | |
| 19a. DATE OF OPERATION 2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED c | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 09 09 1987 to 11 11 1987, that (I) (we) last saw the deceased alive on 10 10 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW J. FORGASH | | | | 22e. ADDRESS 560 RIDERSIDE DRIVE SALISBURY MD 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY WESLEY U.M. CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE VIENNA DORCHESTER MD | | | |
| 24. FUNERAL DIRECTOR NAME JOILEY MEMORIAL CHAPEL | | | | 25a. DATE REC'D. BY REGISTRAR MAY 13 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

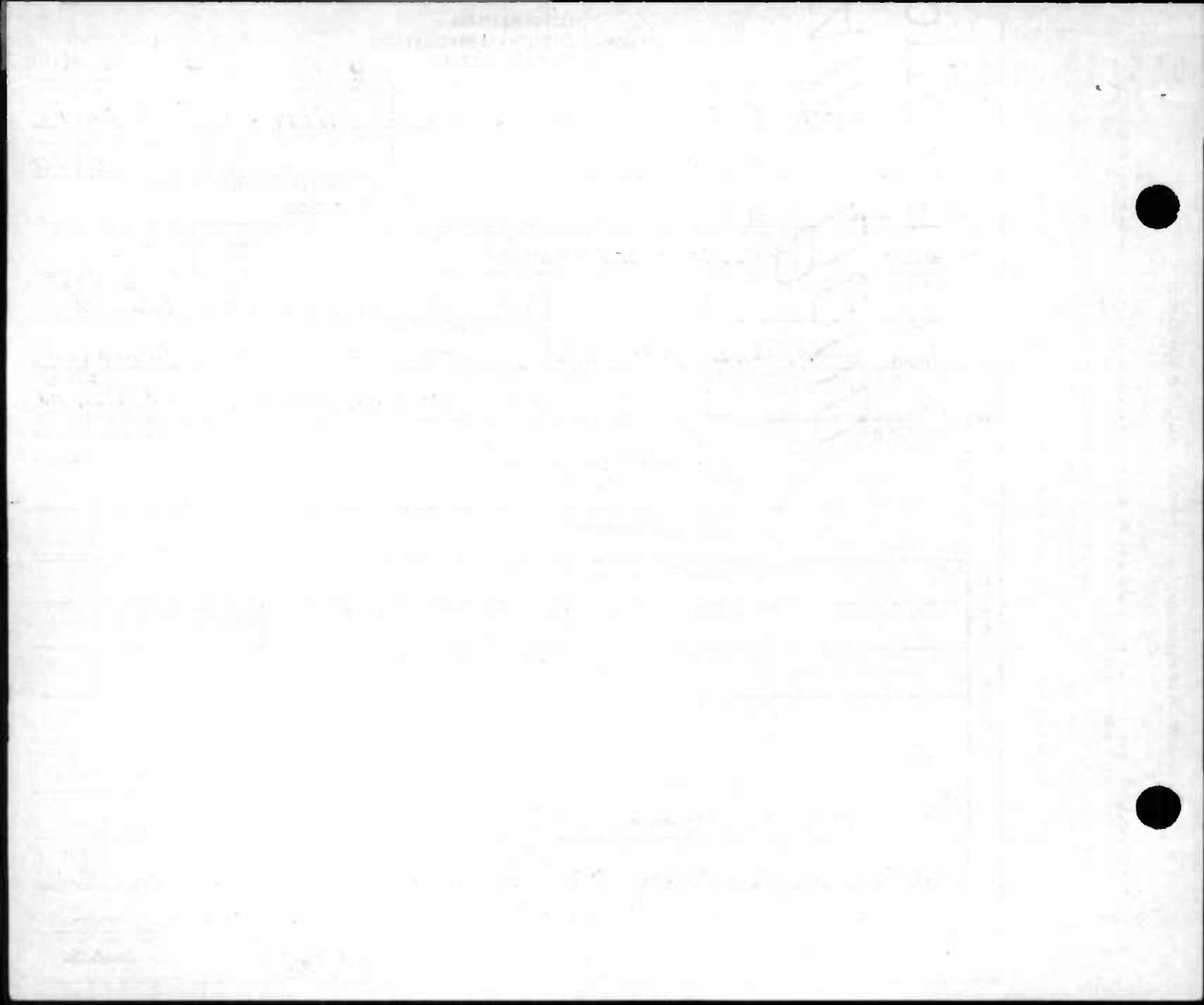
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15544

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| (Baby Girl) JEFFRESS | | May 24 1987 | | 0814 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | Black | MONTH DAY YEAR | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | U.S. | | | Wicomico MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | Peninsula General Hospital | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md | | Wicomico | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Mark Anthony Jeffress, Sr | | Linette Chevelle Sampson | | 13e. STREET ADDRESS / ZIP CODE | |
| | | | | Rt 3, Box 30B Old Delmar Rd 21875 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Mother Rt. 3, Box 30B Old Delmar Rd, Delmar Md. 21875 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Extreme Prematurity | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE | | | | 22b. DATE SIGNED | |
| William W. Clendenen M.D. | | | | 5/27/87 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22d. ADDRESS | |
| William W. Clendenen M.D. | | | | Philip Morris Drive Salisbury Md 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | 05/31/1987 | | Salisbury Crematory | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| Holloway Funeral Home, P.A., Salisbury, Maryland | | JUN 03 1987 | | Arthur Davidson Randall | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15545

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST GEORGE | | MIDDLE | | LAST Johnson | | 2a. DATE OF DEATH MONTH DAY YEAR 1-14-87 | | | | 2b. HOUR 4:25 AM | | | | | |
| 3. SEX M | | 4. RACE BLK | | 5. DATE OF BIRTH MONTH DAY YEAR Nov 12 1902 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wic. | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERWALK MANOR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE md | | 13b. COUNTY Wico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Salisbury Md. 21801 | | | | 115 Second St | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Josh Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Cook | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) I | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Myrtle Cottman | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cerebrovascular Disease | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Urinary Tract Infection, Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Sept 22, 1986, to Jan 14, 1987, that (we) last saw the deceased alive on JAN 14, 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Thomas C. Hill Jr. | | | | | | | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. Hill Jr. | | | | | | | | | | | | 22e. ADDRESS Pine Bluff Road, Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B | | | | 23b. DATE 1-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill MAN | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wico MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John 7/H Salisbury | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 2 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Darden-Randall | | | |

[Faint, illegible handwritten text covering the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

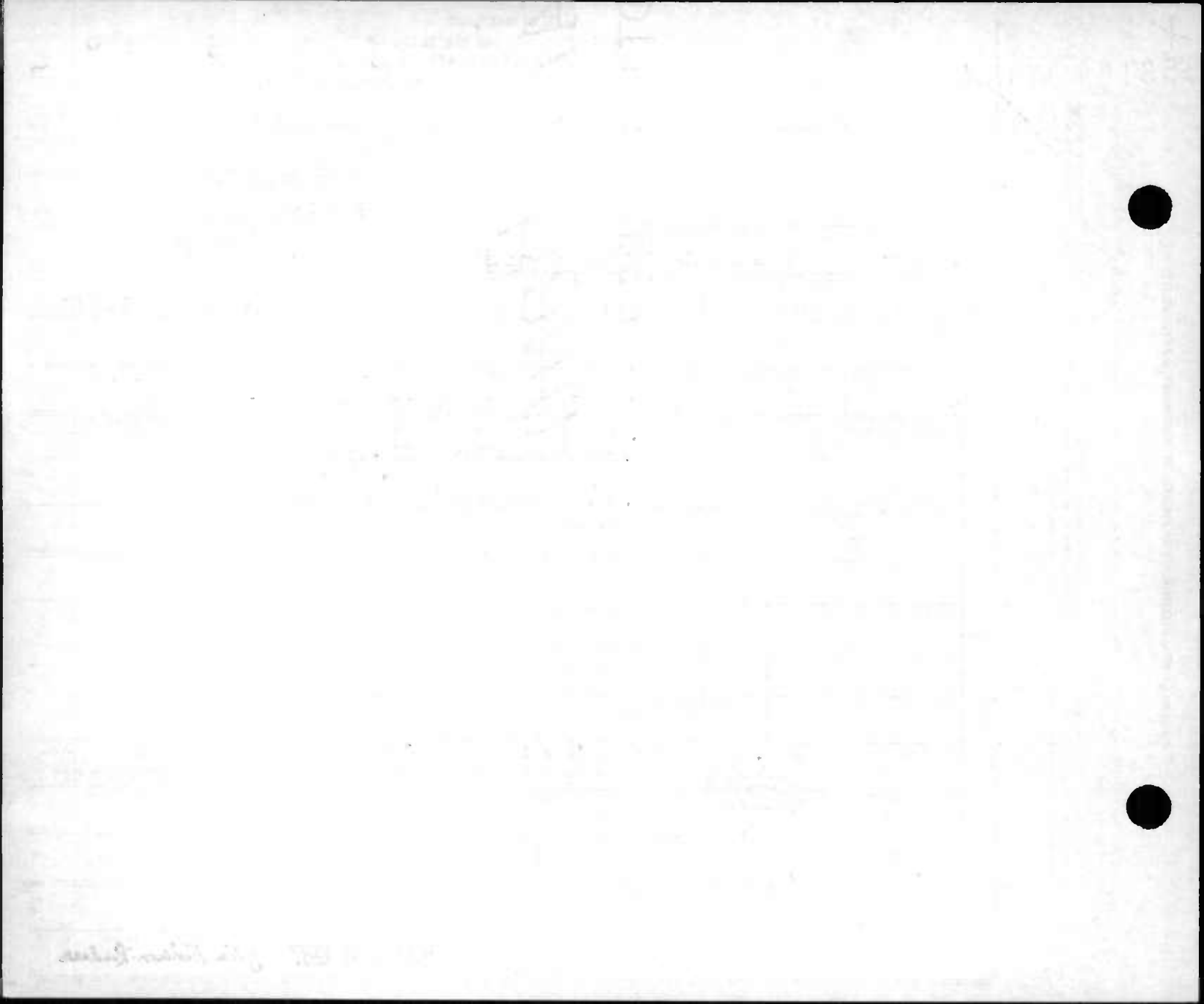
87 15546
REG. NO.

| | | | | | | | |
|---|---|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| CECIL | | JONES | | MAY 3, 1987 | | 0930 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| Female | Black | 1 9 05 | | 82 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | U.S. | | | Wicomico | | MD | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | Peninsula General Hospital | | Homemaker | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | |
| Md. Del. | | Sussex | Del Mar | | Harrison House 19940 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 215-18-4366 | | 1212 Pocohontas Ave. Ms. Jerri Young Salisbury, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Ventricular Aneurysm</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>CAD</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>87</u> , to <u>5/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>sign</u> the body after death | | | | | | | |
| 22b. SIGNATURE <u>G. L. Raffetto</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/3/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. L. RAFFETTO</u> | | 22e. ADDRESS <u>PGH</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Removal | | 5-4-87 | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| State Anatomy Board | | Balto., Md. | | MAY 08 1987 | | <u>Julia S. R. Rader</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



054995 JUN - 119

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15541

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gladys E. Jones</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>May 11, 1987</i> | | 2b. HOUR <i>0825 M</i> |
| 3. SEX <i>F</i> | 4. RACE <i>BLK</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>7-15-16</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN. <i>70</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>md.</i> | 13b. COUNTY <i>Wico</i> | 13c. CITY OR TOWN <i>ALLEN</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <i>Eden Maryland 21822</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>SAMUEL JONES</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula JAMES</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>2K-07-7786</i> | | 17. INFORMANT ADDRESS <i>ELLA M. Nicholas 241. Bt 609 Madelon Sp md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure 2° to</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic undifferentiated Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>to lung and liver, primary source unknown</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/10</i> 19 <i>87</i> to <i>5/11</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>5/10</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Joseph A. Grasso</i> | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>5/11/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso</i> | | 22e. ADDRESS <i>145 E. Carroll St Salisbury MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>5-15-87</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>MT CALVARY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Fruitland Wico. md.</i> | |
| 24. FUNERAL DIRECTOR <i>Adrian James, 407 Somerset Ave. Princess Anne Md</i> | | ADDRESS <i>2183</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 28 1987</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Borden-Rodgers</i> | |

MEDICAL CERTIFICATION

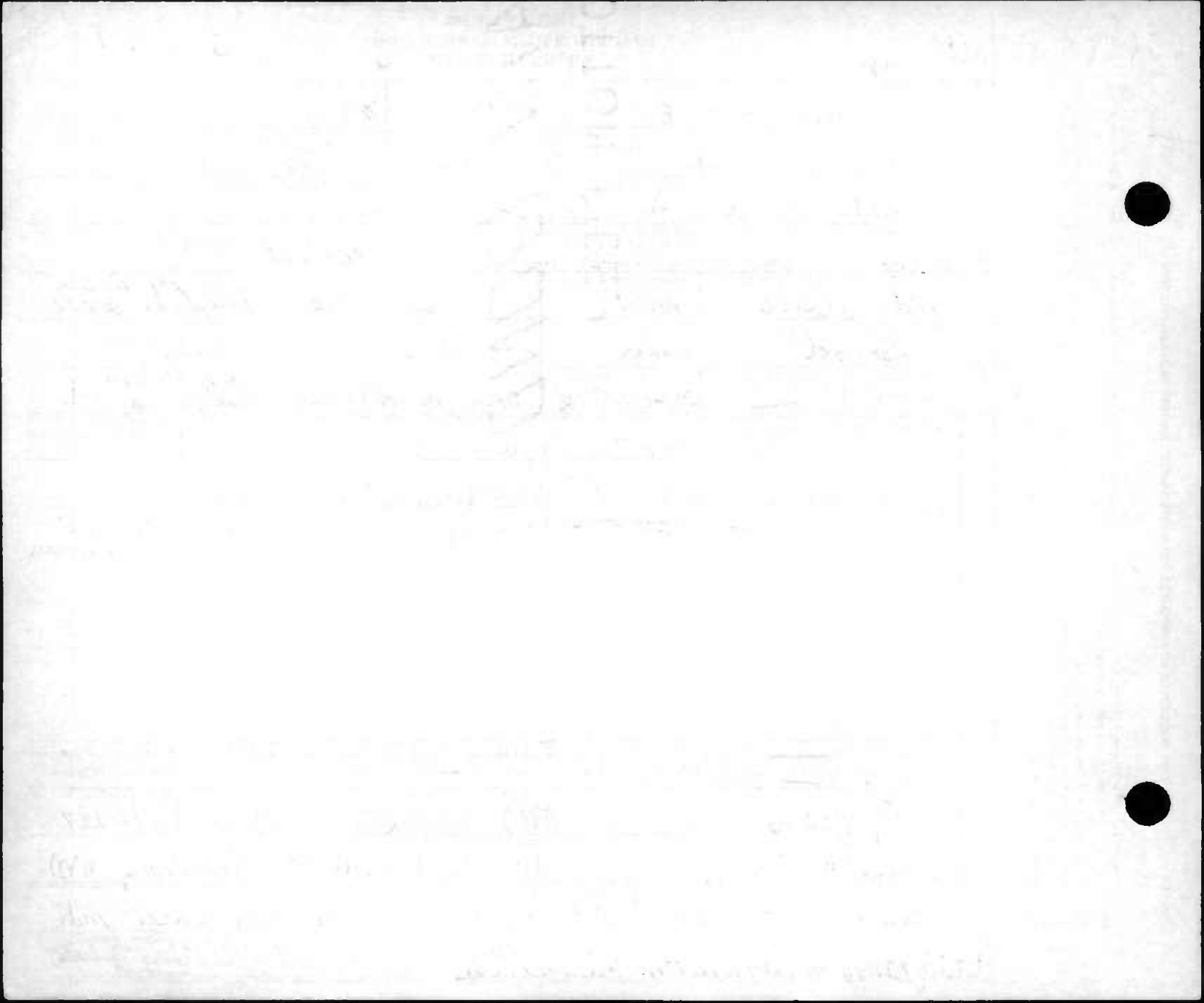
99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP



054169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15548

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--------------------------------|--|-----------------|--|------------------|--|-------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| TIMOTHY MAURICE Knight | | | | | | | | May 15, 1987 | | | | | | | | 0209M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| Male | | White | | Nov. 3, 1905 | | 81 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| USA Virginia | | USA | | | | Wicomico | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Salisbury | | Peninsula General Hospital | | Farmer-Waterman | | Produce-Seafood | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| Virginia | | Accomack | | Hallwood | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD 23359 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Dennard James Knight | | Lovey Hall | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 225-48-3693 | | Mamie Holly Knight | | Hallwood, Virginia | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Cardio Pulmonary Arrest | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | | | |
| Benjamin H Meyer MD | | | | | | 5/15/87 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| BENJAMIN MEYER MD | | PENINSULA GENERAL HOSPITAL MEDICAL CENTER | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 5/17/87 | | John W. Taylor Memorial | | Temperanceville Accomack Va. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| John J. Williams | | P.O. Box 527 Parksley, Va. | | MAY 19 1987 | | John J. Williams | | | | | | | | | | | |

●



53028 MAY 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

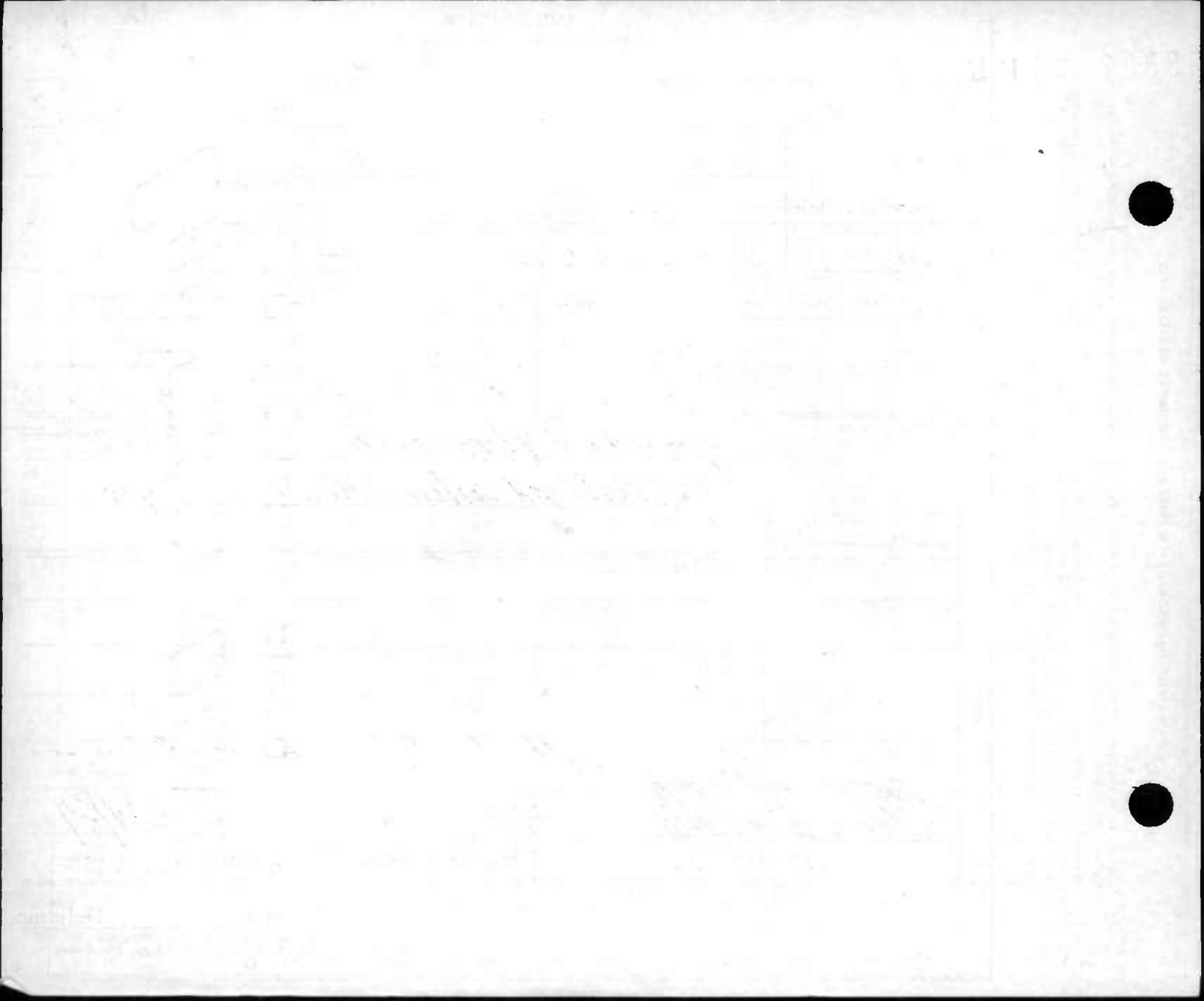
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 15549

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME FIRST MIDDLE LAST Ruth IRENE LEE | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 2-1987 | | 2b. HOUR P M 2:00 P | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 07 11 1917 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wilmington, Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Retail | | | |
| 13a. STATE Delaware | | 13b. COUNTY New Castle | | 13c. CITY OR TOWN New Castle | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 101 Halcyon Drive 19720 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Stiles | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Westcott | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 221-09-0238 | | 17. INFORMANT ADDRESS Diane M. Collins 202 W. Philadelphia Avenue, Salisbury, Md. 21801 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk yes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-7 1987 to 5-2 1987 , that (I) met last saw the deceased alive on 5-1 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If certifier did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE Earl M. Beardsley | | DEGREE MD | | 22c. DATE SIGNED 5/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY M.D. | | 22e. ADDRESS Rte 50 & Civic Avenue, Salisbury, Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 05/05/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington Delaware | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Sanders-Rudner | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15550

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA ESTHER LEONARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 25 87 | | 2b. HOUR 10 ³² a.m. |
| 3. SEX F | 4. RACE BLK | 5. DATE OF BIRTH MONTH DAY YEAR 2 14 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DEAL Island | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Housekeeper |
| 13a. STATE Md | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN SALISBURY | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 21801 344 Delaware Ave |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Jones | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Milbourne | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | 16b. SOCIAL SECURITY NO. 215-14-3941 | | 17. INFORMANT ADDRESS VONETTE DAVIS Add. Same as Above | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1986, 19, 5-25, 1987, that (I) (we) last saw the deceased alive on 5-25, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Roger Merrill | | DEGREE M.D. | 22c. DATE SIGNED 5-25-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER MERRILL, M.D. | | 22e. ADDRESS 100 Power St. SALISBURY, Md. 21801 | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5-29-87 | 23c. NAME OF CEMETERY OR CREMATORY Green Acres | 23d. LOCATION CITY OR TOWN COUNTY STATE West Rd. SALISBURY-Wi- Md. |
| 24. FUNERAL DIRECTOR NAME Jolley Mem. Chapel - Rt. #12 Box 920 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 1 1987 John Anderson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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22000

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Library" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15551

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| GEORGE E. Littleton | | | | May 6, 1987 | | 0248m | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | white | July 30, 1921 | | 65 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Laurel, DEl. | USA | | | Wicomico MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | Peninsula General Hospital | | | Farmer | | own farm | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | |
| Delaware | | Sussex | Laurel | | RD 3 Box 245 99999 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Elmer C. Littleton | | | Sally Twilley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| no | | 173 20 4297 | | Margaret M. Littleton R 3 box 245 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b and 10c.) PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CAD</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2, 19 87, to 5/7, 19 87, that (I) (we) lost saw the deceased alive on 5/7, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>J. L. Raffetto</u> DEGREE <u>MD</u> | | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. L. RAFFETTO</u> | | | | | 22e. ADDRESS <u>BGH</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| burial | | 5/9/87 | Odd Fellows Cem. | | Laurel Sussex DE | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Homer L. Disharoon box 678 Laurel, DE 19956 | | | | MAY 11 1987 | | Julia Davidson-Randall | |

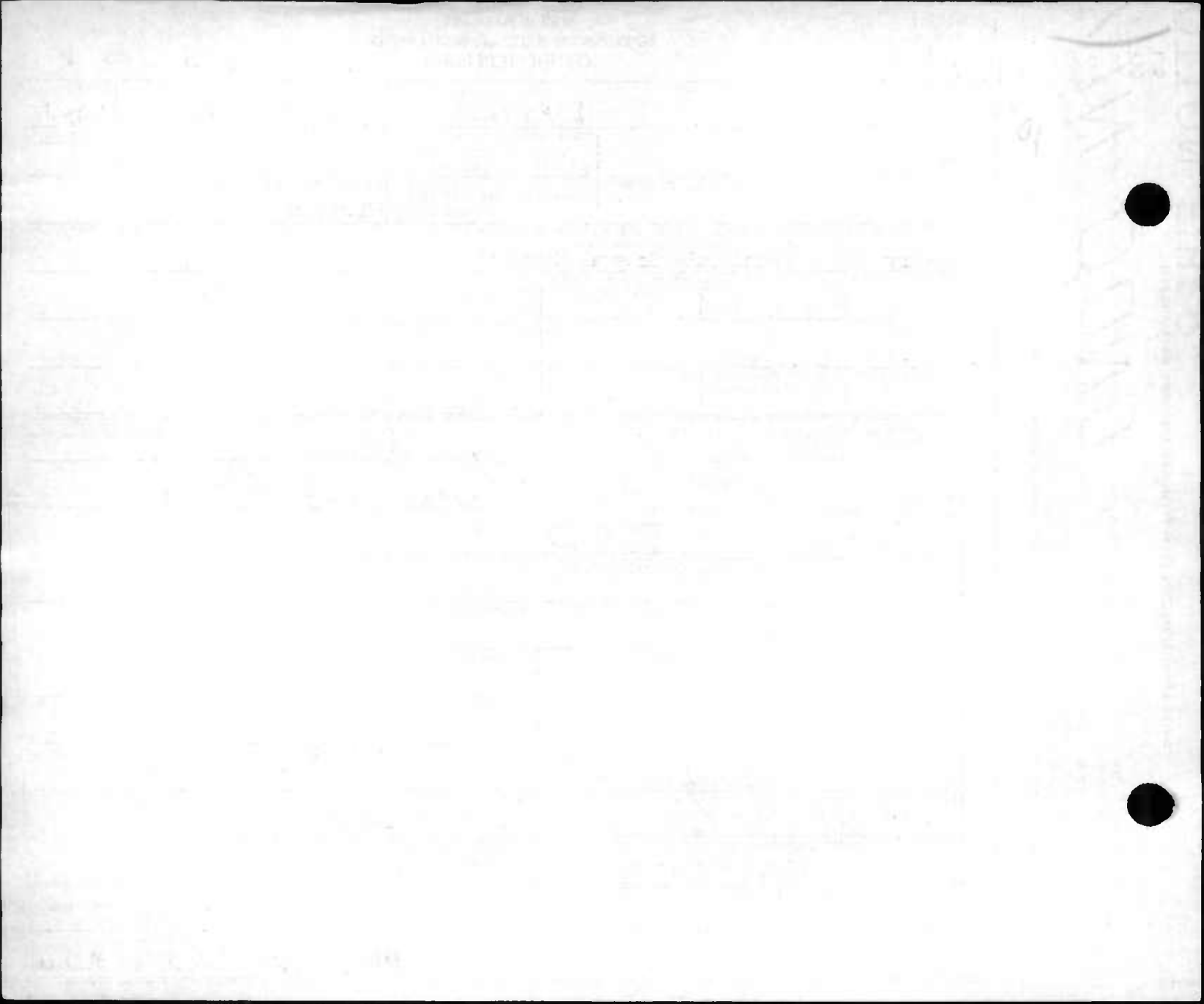
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. 2. AND 3 TO THE FUNERAL DIRECTOR. PAGE 1 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR 415 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5552

| | | | | | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| WYLE WOODLAND MADDOX III | | 5-1-87 19 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Male | White | June 22, 1962 | 24 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Virginia | U. S. A. | WIDOWED | DIVORCED | Wicomico County | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | Peninsula General Hospital | Construction | | Self | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Virginia | Accomack | Chincoteague | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Piny Island 23336 99999 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| Wayne Maddox | Kathryn Bogush | No | | | |
| 16a. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 231-98-0257 | Sylvia L. Maddox | Chincoteague, Virginia | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Head injuries | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | 1:45P 5-1-87 19 | | struck by boom of a crane at work site | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | work site | | Property of Ken Anderson, Captains Hill W. Ocean City Worcester Co., Maryland | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| 22b. I certify that I took charge of the remains described above, held on death resulted from | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| John E. Smialek, M.D. | | Chief | | 5-2-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| John E. Smialek, M.D. | | 111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | 5-5-87 | Downing Cemetery | | Oak Hall, Virginia | |
| 24. FUNERAL DIRECTOR | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | |
| Constance Salzman Gordon | | | MAY 07 1987 | | |
| 26. REGISTRAR'S SIGNATURE | | 27. REGISTRAR'S SIGNATURE | | | |
| Julia Dindon-Randall | | Julia Dindon-Randall | | | |

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15553
REG. NO.

| | | | | |
|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MARRIA MADRICAL | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 9, 1987 | | 2b. HOUR 0830 M |
| 3. SEX Female | 4. RACE Mexican | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY None |

| | | | | | |
|--|--|--|-------------------------------|---|---|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Va | | 13b. COUNTY Accomack | 13c. CITY OR TOWN Gargatha | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE RFD Parkesley 23421 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Chacho Muniz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS Amanda Williams New Church Va 23415 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 4-30 19 87 to 5-9 19 87, that (I) (we) last saw the deceased alive on 5-9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Dennis J. Chodnicki MD | | DEGREE MD | 22c. DATE SIGNED 5/9/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|--|---------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE May 12, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Downing Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Oak Hall Accomack Co. Va |
| 24. FUNERAL DIRECTOR NAME Nebot | | 25. DATE REC'D BY REGISTRAR 05/12/87 25b. REGISTRAR'S SIGNATURE | |

7

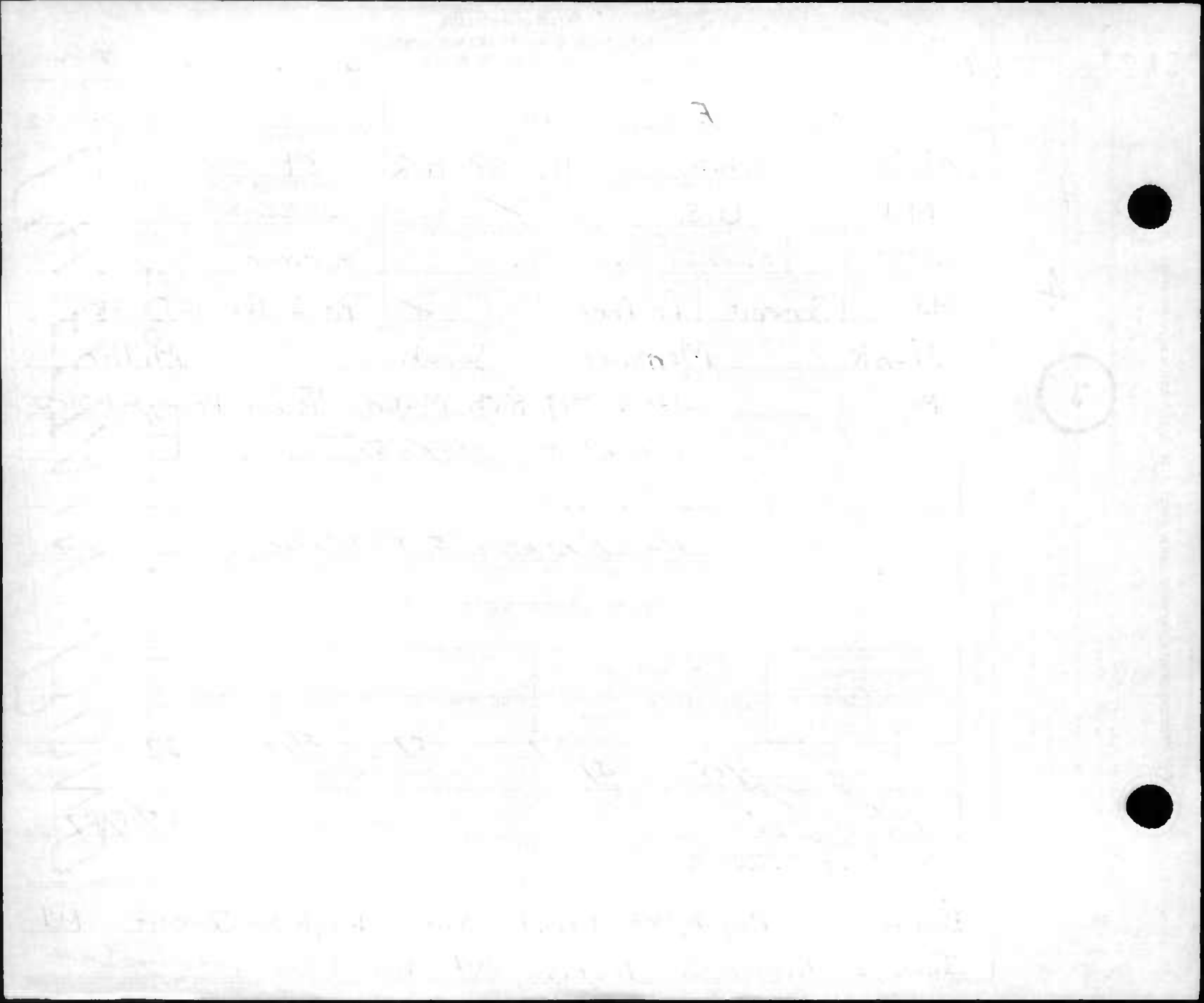
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REC. NO. 15554

| | | | | | |
|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEROY F. MARRINER | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 17 87 | | 2b. HOUR 3:30 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 08 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | |
| 10. CITY OR TOWN OF DEATH SALISBURY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | 13b. COUNTY Somerset | 13c. CITY OR TOWN Pc Anne | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE Rt 2, Box 125 21853 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Mariner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Miller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-16-7784 | | 17. INFORMANT Ruth Mason ADDRESS Rt 2 Princess Anne, Md 21853 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) STROKE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) ALZHEIMER'S DISEASE | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15/87 to 5/17/87 , that (I) (we) lost saw the deceased alive on 5/15/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. | | | | | |
| 22b. SIGNATURE William H. Robins | | DEGREE | | 22c. DATE SIGNED 5/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. ROBINS, MD. | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 20, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Perryhawkin | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Perryhawkin Somerset Md | | 24. FUNERAL DIRECTOR NAME ADDRESS James L. Hiarman Jr Pc Anne, Md | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |



Re sent
53673 MAY 18
7/2/87 km

#5,17, Film G628 6/11/87 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 5555

| | | | | | | | | | | | | | |
|--|---------|--|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | xx MONTH DAY YEAR | | 2b. HOUR | |
| James Henry Mattingly | | | | | | | | 5 12 19 87 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male. | White. | July 23, 1924 | | 62 | | | | | | 5 12 19 87 | | 3:10 P.M. | |
| 7a. BIRTHPLACE (STATE OR COUNTY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland. | | U. S. A. | | WIDOWED | | DIVORCED | | Wicomico County, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Salisbury | | Peninsula General Hospital | | Builder (Real Estate) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Geo. | | Hyattsville. | | YES X NO | | 1307 Nicholson St. | | 20782 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| James H. Mattingly | | Clara Mae Wallace | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Wife | | ADDRESS | | | | | |
| YES | | 218-14-2026 | | EVELYN A. MATTINGLY | | 1307 NICHOLSON ST. HYATTS MD | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES X NO | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE William M. Zane TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 5/13/87

EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St. Balto.MD.

| | | | |
|---------------------------------|--------------|------------------------------------|----------------------------|
| 73a. BURIAL, CREMATION, REMOVAL | 73b. DATE | 73c. NAME OF CEMETERY OR CREMATORY | 73d. LOCATION CITY OR TOWN |
| BURIAL | MAY 16, 1987 | FORT LINCOLN CEMETERY | BALTIMORE |
| 73e. DATE RECEIVED BY REGISTRY | | | |
| MAY 15 1987 | | | |

73f. REGISTRY ADDRESS

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

X

X

Q11

Q11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--------|--|------------------|--|------------------|
| 1- REGISTRAR | | FOR | | REG. NO. 5556 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | LAST | |
| Francis | | P. | | McDermott | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Male | White | MONTH 1 DAY 22 YEAR 18 | 69 | MONTHS | DAYS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Philadelphia, Pennsylvania | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. DATE KNOWN OF DEATH | | 11. DATE OF DEATH | |
| Wicomico | | MONTH 5 DAY 26 YEAR 1987 | | MONTH 5 DAY 26 YEAR 1987 | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Salisbury | | Peninsula General | | Rigger | |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 16. STATE | | 17. COUNTY | |
| Pennsylvania | | Philadelphia | | Philadelphia | |
| 18. FATHER'S NAME | | 19. MOTHER'S MAIDEN NAME | | 20. STREET ADDRESS | |
| Harry | | Margaret | | 2403 East Boston | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 22. SOCIAL SECURITY NO. | | 23. INFORMANT | |
| Yes | | WWII | | 185-03-2191 | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 26. YEARS | |
| PART 1 DEATH WAS CAUSED BY: | | Arterioscleritic Cardiovascular Disease | | years | |
| IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 27a DATE OF OPERATION | | 27b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 28 AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 29a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 29b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 29c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 30a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 30b PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 30c LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 31 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| 32 ACTUAL SIGNATURE | | 33 TITLE (SPECIFY) | | 34 DATE SIGNED | |
| John T. Bulkeley | | Deputy | | 5-26-87 | |
| 35 EXAMINER'S NAME (TYPE OR PRINT) | | 36 ADDRESS | | 37 MEDICAL EXAMINER | |
| John T. Bulkeley | | Salisbury, Maryland | | | |
| 38 BURIAL, CREMATION, REMOVAL (SPECIFY) | | 39 DATE | | 40 NAME OF CEMETERY OR CREMATORY | |
| Burial | | 05/30/1987 | | Holy Sepulchur Cemetery | |
| 41 LOCATION CITY OR TOWN | | 42 COUNTY | | 43 STATE | |
| Wymoor, Montgomery, Pennsylvania | | | | | |
| 44 FUNERAL DIRECTOR NAME | | 45 ADDRESS | | 46 DATE REC'D. BY REGISTRAR | |
| Holloway Funeral Home, P.A., Salisbury, Maryland | | | | 5-26-87 | |
| 47 REGISTRAR'S SIGNATURE | | 48 DATE | | 49 | |
| | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 724. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

999999
BP
DHMH-17
(VR A15 ME (S))

WEST NOTION CO. 20% COTTON FIBER

054095 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

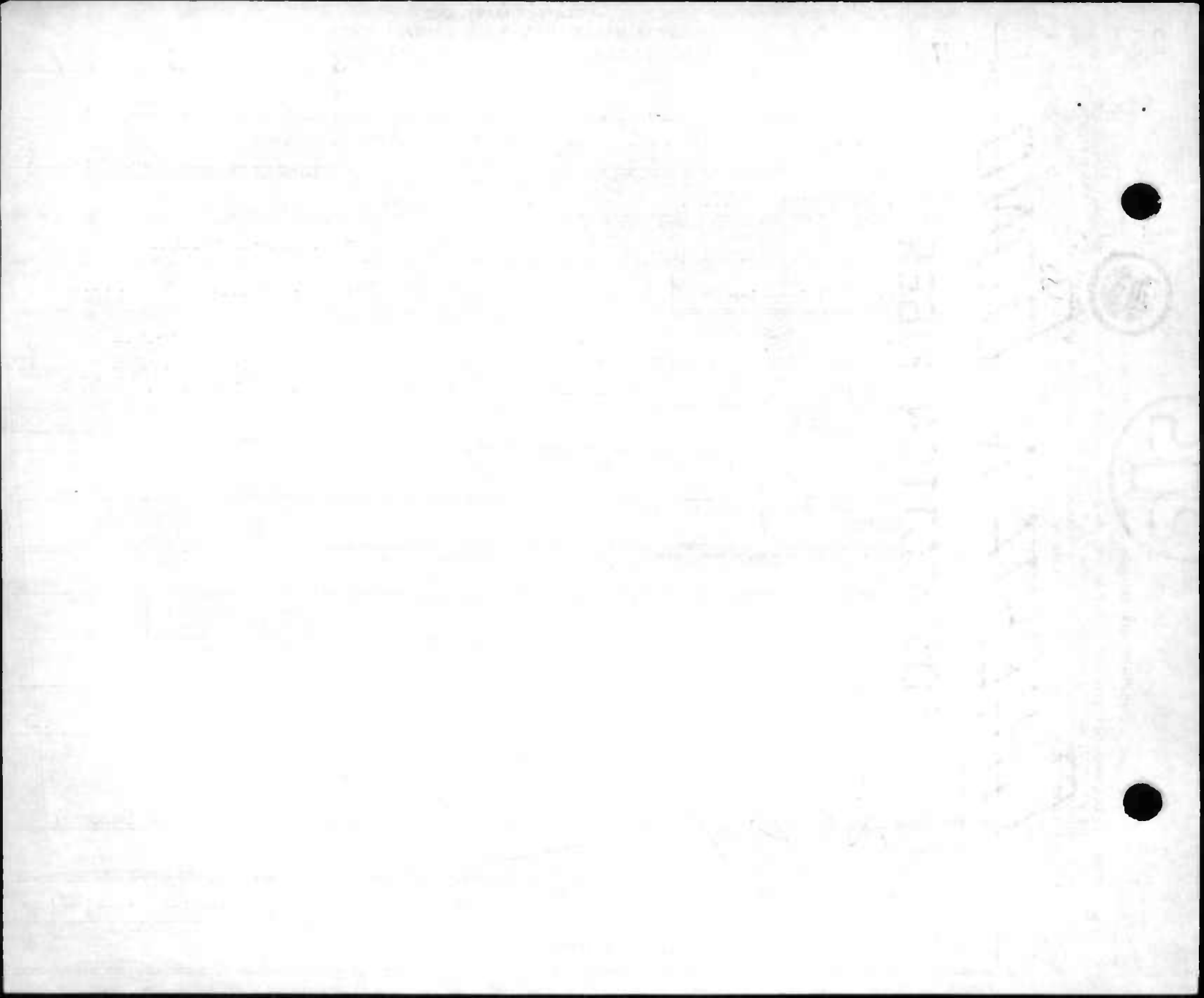
FOR
1-STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 555

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| RICHARD L. MEADOWS | | | | | | | | DATE KNOWN OF DEATH | | HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | |
| Male | | White | | 01 02 1958 | | 29 YRS. | | MONTHS | | DAYS | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. DATE PRONOUNCED DEAD | | 10. HOUR | |
| Salisbury, Maryland | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Wicomico County | | 5 22 1987 | | 10:29 P.M. | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Salisbury | | Peninsula General Hosp. (DOA) | | Construction Worker | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. ZIP CODE | |
| Maryland | | Wicomico | | Hebron | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 512 Main Street | | 21830 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Wheeler S. Meadows | | Betty Fisher | | 220-68-9957 | | Wheeler S. & Betty Meadows (Parents) | | | | | |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 18. SOCIAL SECURITY NO. | | 17. INFORMANT | | Star Route Box 10, Salisbury, Md. 21801 | | | | | |
| No | | 220-68-9957 | | Wheeler S. & Betty Meadows (Parents) | | Star Route Box 10, Salisbury, Md. 21801 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple injuries | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| 8/1/87 | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 9:16M. 5-22- 1987 | | Pedestrian struck by auto. | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | 21g. CITY OR TOWN | | 21h. COUNTY | | 21i. STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | road | | Rt. 50 w. of Rt. 90 | | Worcester | | MD | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| death resulted from: | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Ann M. Dixon, M.D. | | Deputy Chief | | 5-23-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Pern St., Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. COUNTY | | 23f. STATE | |
| Burial | | 05/26/1987 | | Springhill Memory Gardens | | Hebron, Wicomico, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Holloway Funeral Home, P.A., Salisbury, Maryland | | MAY 28 1987 | | | | | | | | | |

07/84
25AADHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15558

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORA Gertrude MERRITT | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 07 1987 | | 2b. HOUR 9:00 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 08 22 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George I. Adkins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-10-9052A | | 17. INFORMANT Mr. Charles F. Merritt, Jr. (Son) 1524 Alpha Court, Columbia, S. C. 29223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>The.</i> <i>yes.</i> | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Diabetes - Generalized arterio sclerosis - Dementia</i> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>5-7</i> 19 <i>87</i> , to <i>5-7</i> 19 <i>87</i> , that (1) was last saw the deceased alive on <i>5-7</i> 19 <i>87</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. If we <i>we</i> did not <i>did not</i> view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Earl M. Beardsley</i> | | | | DEGREE M.D. | | 22c. DATE SIGNED 5/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | | | 22e. ADDRESS CIVIC AVE. & RT. 50, SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 05/11/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1987 | | 25b. REGISTRAR'S SIGNATURE <i>La. Davidson-Randall</i> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5559

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------|---------------|--|--|---|--|---|-----------------|---------------------------------------|--|---|--|-------|------------------|--|--|-----------|--|---|--------------|--|--|------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Paul | | | MIDDLE Anthony | | | LAST Miklich | | | 2b. DATE KNOWN OF DEATH ESTI- MATED | | | MONTH 5 | | | DAY 17 | | | YEAR 1987 | | | 2d. HOUR 0210 | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 6 11 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 17 1987 | | | 2d. HOUR 0219 | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner | | | | 12b. KIND OF BUSINESS OR INDUSTRY Mining | | | | | | | | | | |
| 13a. STATE Virginia | | | | 13b. COUNTY Pr. William | | 13c. CITY OR TOWN Woodbridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 13617 Rush Dr. | | | | 22102 | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Miklich | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Movak | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | | | | 16b. SOCIAL SECURITY NO. 185-03-2032 | | | | 17. INFORMANT ADDRESS Paul A. Kiklich, Jr. See #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 90 mins years | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. <u>Chronic Obstructive Pulmonary Disease ("Black Lung")</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John T. Bulkeley</u> | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-17-87 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D. | | | | ADDRESS Salisbury, Maryland | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 5/21/87 | | | | 23c. NAME OF CEMETERY OR CREMATORY Everly F H Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Everly Funeral Home | | | | | | | | 10565 Main St Fairfax, Va. | | | | 25a. DATE REC'D BY REGISTRAR MAY 21 1987 | | | | 25b. REGISTRAR'S SIGNATURE Julia Seaton-Randall | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

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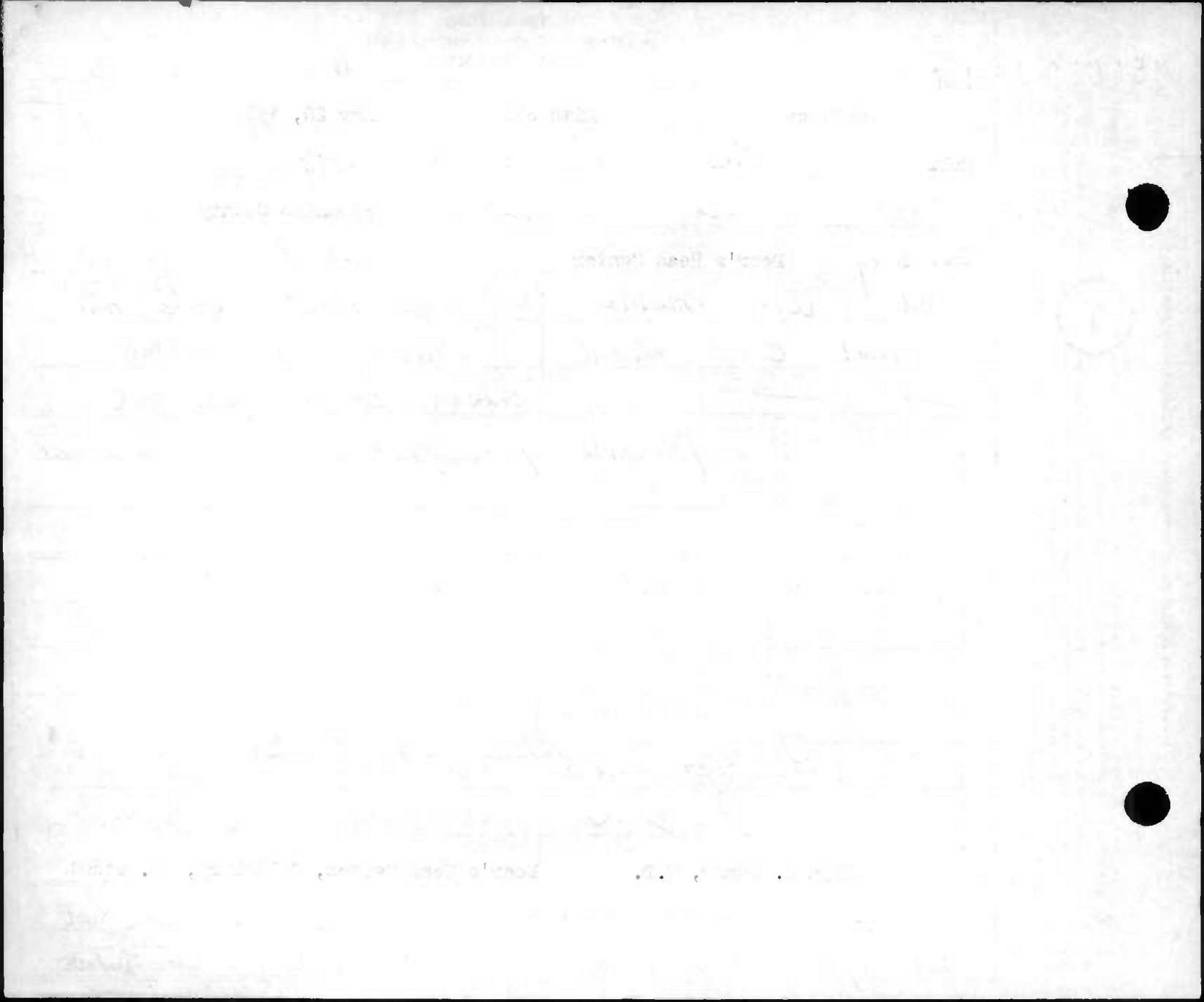
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Matthew | | MIDDLE Mitchell | | LAST Mitchell | | 2a. DATE OF DEATH MONTH DAY YEAR May 20, 1987 | | 2b. HOUR 7:45 P.M. | |
| 3 SEX Male | | 4 RACE Blk | | 5. DATE OF BIRTH MONTH DAY YEAR 1 29 59 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DREL | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Saw mill | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Wico | | 13c. CITY OR TOWN Mardela | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Mardela Springs | | ZIP CODE 21837 | |
| 14. FATHER'S NAME FIRST Alford MIDDLE C. LAST Mitchell | | 15. MOTHER'S MAIDEN NAME FIRST Flossie MIDDLE A. LAST Mitchell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS SOWAR SMITH Doris DREL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10 End stage renal disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20 1987 to 5/20 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Inja J. Hwang, M.D. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22f. DATE SIGNED 5/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS Deer's Head Center, Salisbury, MD. 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-25-87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Ch. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Columbia Sussex DREL | | | | | |
| 24. FUNERAL DIRECTOR NAME Fuchs F/H Salisbury Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1987 | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of same.



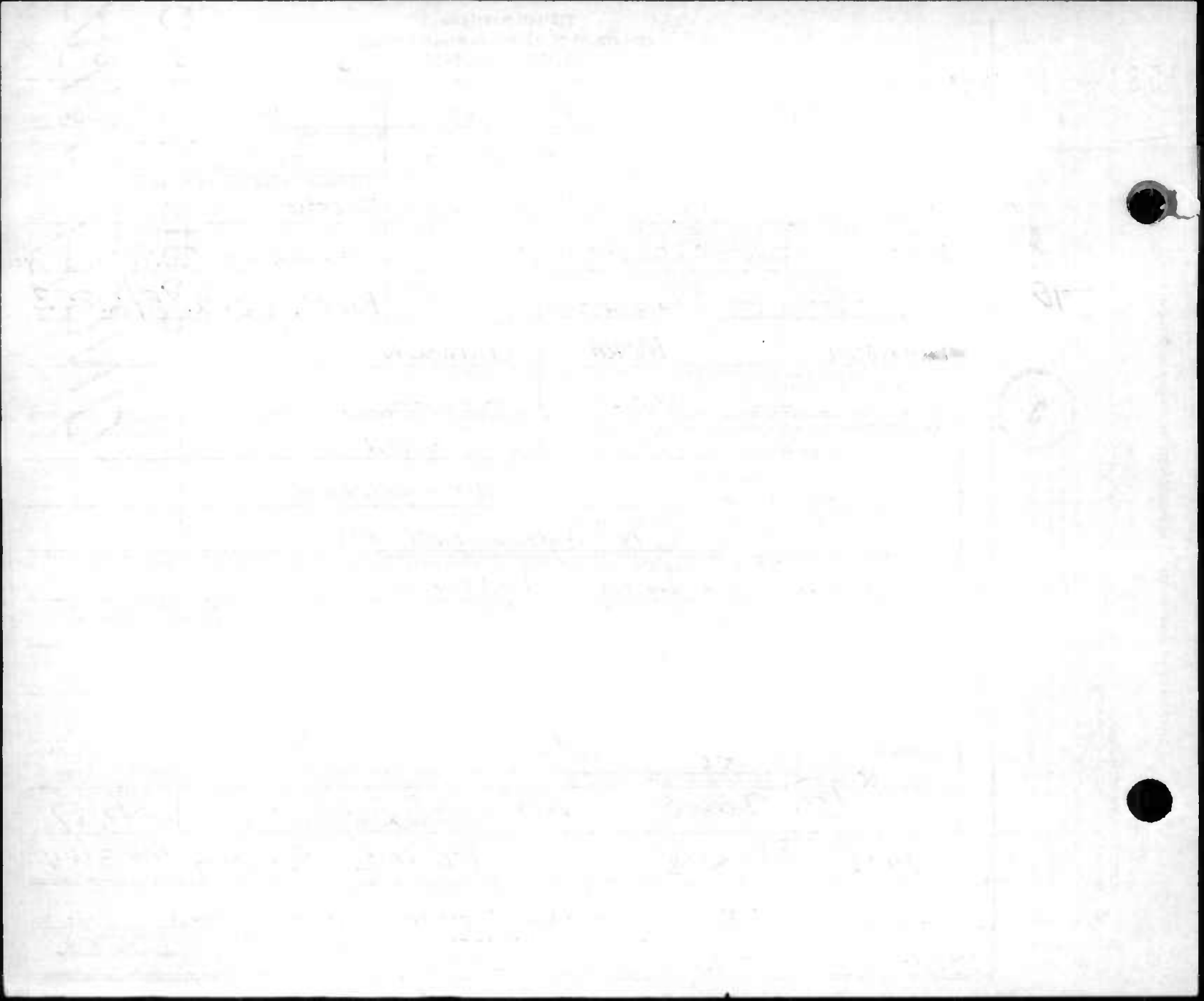
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, a coroner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15561

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | VICTOR | | Moore, SR. | | May 6, 1987 | | 1555 M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | | NEGRO | | 11 11 11 | | 76 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Dominican Repub. | | U.S.A. | | | | Wicomico | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Peninsula General Hospital | | retired-laborer | | N.Y. School Sys. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | SOMERSET | | Princess Anne | | | | Rt. #2 BOX 218E/21853 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Unknown | | MORA | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | |
| no | | 116-05-6510 | | Victor Moore, JR. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Ac. Anterior wall MI</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CAD old by MI Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> , 19 <u>87</u> , to <u>5/6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>B. Agnew</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/7/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BAL AGNEW</u> | | 22e. ADDRESS <u>PGHMS - Salisbury Md 21801</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>5/11/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Grace U.M. Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Venton Somerset MD</u> | | | |
| 24 FUNERAL DIRECTOR NAME <u>JOLLEY MEMORIAL CHAPEL</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAY 13 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u> | | | | | |



052799 MAY 1987

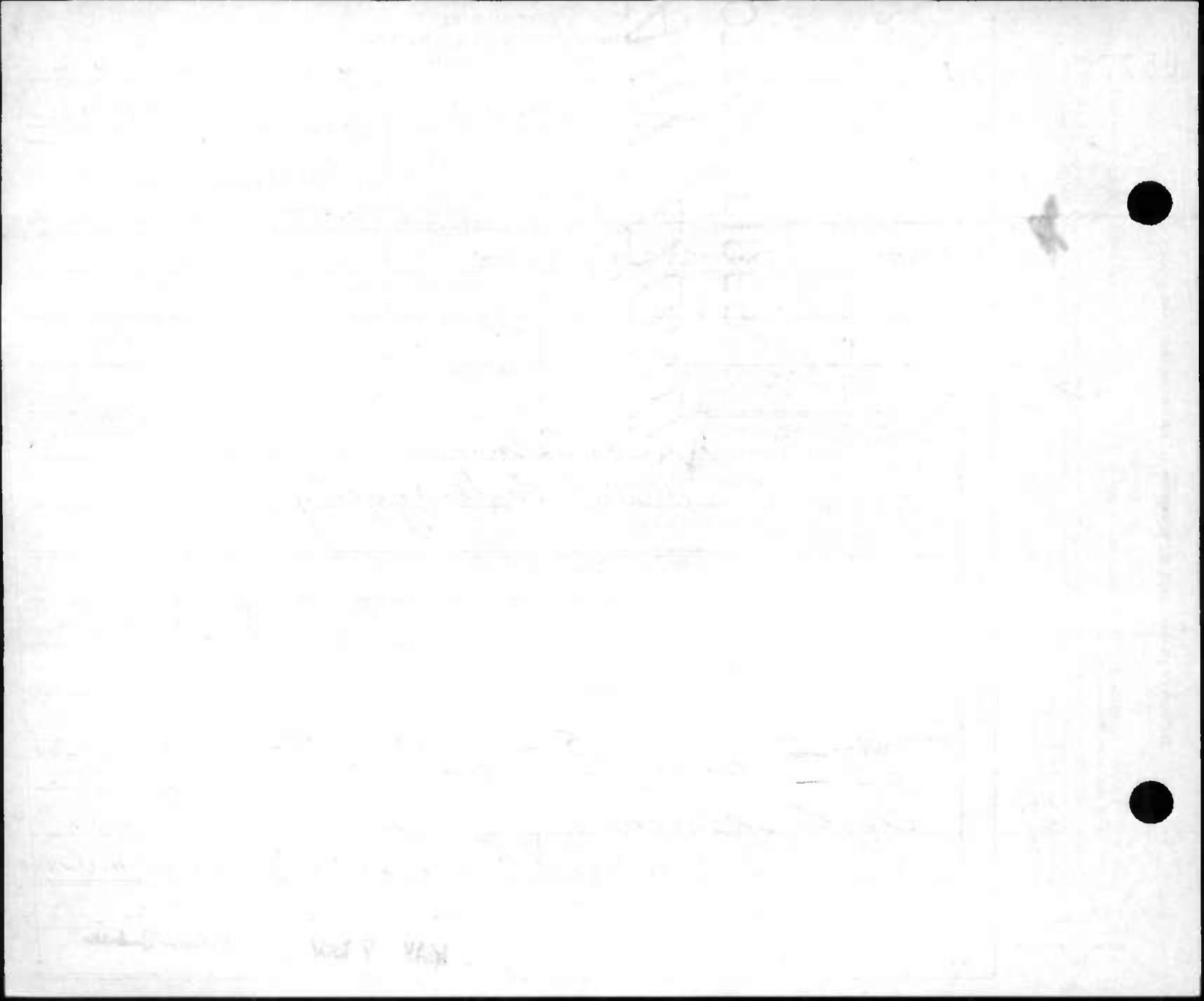
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAULINE ISABELLE MORGAN | | | | | | | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR 5 2 87 | | 2b. HOUR 1830 M | | | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 17, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELMAR, DELAWARE | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 12. CITY OR TOWN OF DEATH Salisbury | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 15. KIND OF BUSINESS OR INDUSTRY Home | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware 13b. COUNTY Kent 13c. CITY OR TOWN Harrington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 8 Ward Street 99999 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Wilson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Wilson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 222-12-2387 | | 17. INFORMANT ADDRESS Patricia Lankford Harrington, Del. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>dilated Cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (in hospital) attended the deceased from 5/2/87, 19 87, to 5/2/87, 19 87, that (2) (at home) saw the deceased alive on 5/2/87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Clayton L. Radabaugh | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/2/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton L. Radabaugh | | | | 22e. ADDRESS PO BOX 2636 Salisbury MD 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 6, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Harrington, Delaware | | | |
| 24. FUNERAL DIRECTOR NAME William Fleischauer Jr. Greenwood, Del. | | | | 25a. DATE RECD. BY REGISTRAR MAY 7 1987 | | 25b. REGISTRAR'S SIGNATURE John D. ... | | | |



054296 MAY 22

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15563

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia E Morris | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-87 | | 2b. HOUR 7:00 PM |
| 3. SEX F | 4. RACE BLK | 5. DATE OF BIRTH MONTH DAY YEAR 4 10 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | 7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Quantico | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD. | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 268 W. Line St. 21801 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charlie Rider | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Winder | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 8A-05-3510 | 17. INFORMANT ADDRESS Patrick Morris 4319 Lock Raven Blvd Balto, Md. 21218 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Resp Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASD - Alzheimer Dis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-8-87 19 to 5-12-87 19, that (I) (we) last saw the deceased alive on 5-12-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE K17 | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-16-87 | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem. Gard. | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR Jolley Memorial Chapel | | ADDRESS Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 21 1987 | 25b. REGISTRAR'S SIGNATURE Julia Winder-Landman |

MEDICAL CERTIFICATION

9
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the office of the registrar, it should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED

POWER

CHIEF

20%

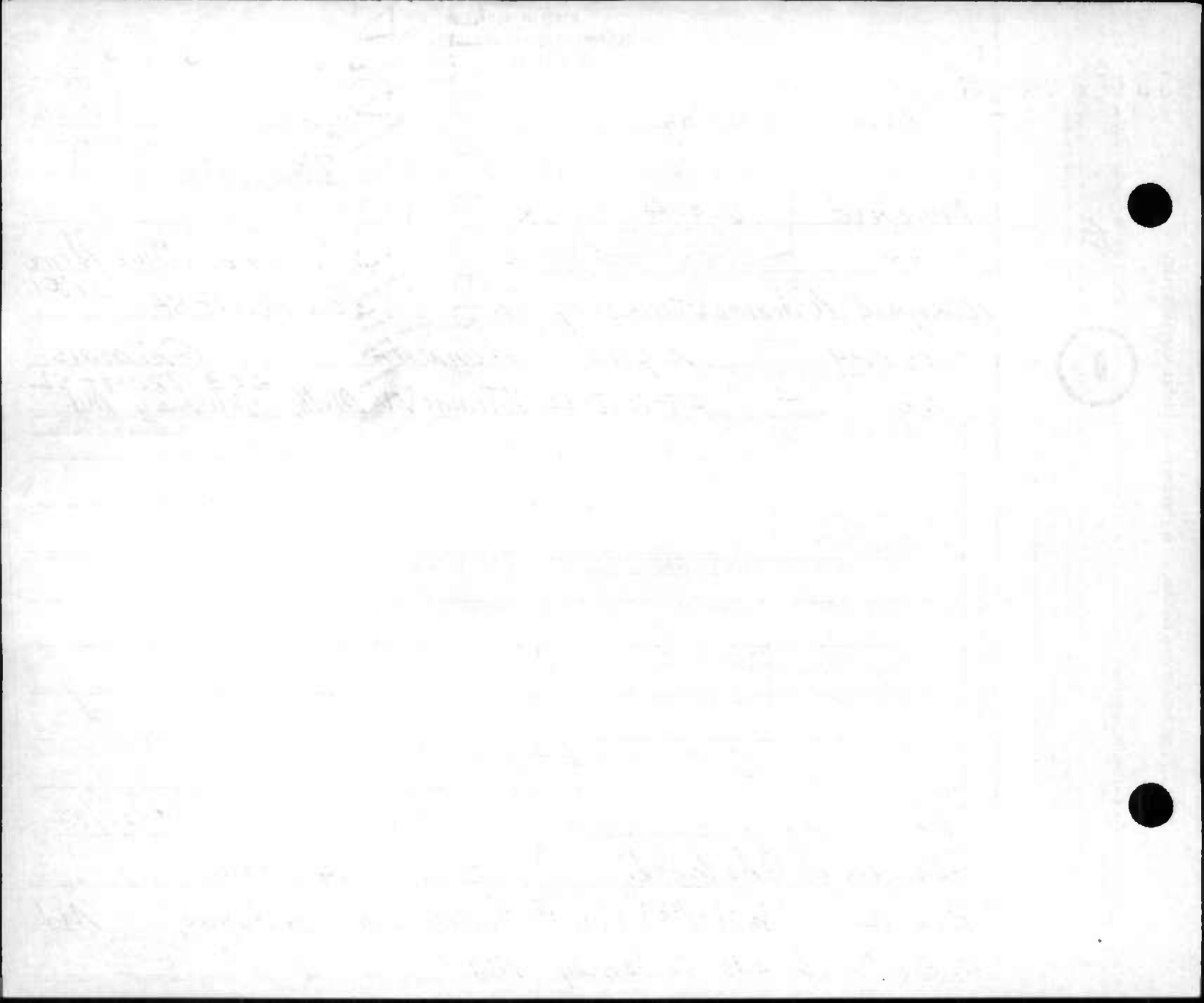
[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15564

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ROSE Dorothy Muth | | | 2a. DATE OF DEATH MONTH DAY YEAR May 28 1987 | | 2b. HOUR 00.30 AM |
| 3. SEX Female | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 10-3-1910 | | 6. AGE YEARS (LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 13a. STATE MARYLAND | | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH Egan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUANITA GRIMMS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-78-8122 | | 17. INFORMANT Thomas M. Muth, Salisbury, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 87 , to 5/28 , 19 87 , that (I) (we) last saw the deceased alive on 5/28 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dennis J. Chodnicki | | | | 22c. DATE SIGNED 5/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis J. Chodnicki | | | | 22e. ADDRESS Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 6-1-1987 | | 23c. NAME OF CEMETERY OR CREMATORY New Catholic Cem. Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Baker & Bounds | | ADDRESS Salisbury Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia D. Anderson-Rudolph | |



054379 MAY 21 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15565

| | | | | | |
|--|--|---|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Layfield Nock | | | 7a DATE OF DEATH MONTH DAY YEAR May 20 1987 | | 7b HOUR 4:30 PM |
| 2 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10 CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 229 Canal Woods | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b KIND OF BUSINESS OR INDUSTRY State Senator |
| 13a STATE Maryland | 13b COUNTY Wicomico | 13c CITY OR TOWN Salisbury | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 229 Canal Woods 21801 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William T. Layfield | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu Taylor | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | 17 INFORMANT ADDRESS Garland Nock see sec 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Lymphocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Cerebral Arteriosclerosis with old Cerebral Infarctions</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) <u>this hospital</u> attended the deceased from <u>Oct 22</u> , 19 <u>62</u> , to <u>May 20</u> , 19 <u>87</u> that (I) <u>have</u> last saw the deceased alive on <u>May 4</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Thomas C Hill Jr.</u> | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>5/21/87</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS C. HILL JR</u> | | 22e ADDRESS <u>Pine Bluff Road, Salisbury, Md</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b DATE <u>5-24-1987</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u> | | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury, Wicomico, Md.</u> |
| 24 FUNERAL DIRECTOR NAME <u>Baker & Bounds</u> ADDRESS <u>Salisbury, Maryland</u> | | | 25a DATE REC'D BY REGISTRAR <u>MAY 21 1987</u> 25b REGISTRAR'S SIGNATURE <u>Julia London-Rudell</u> | | |

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



054896

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15565
REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH PRISCILLA NORMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 22 1987 | | 2b. HOUR 1400 M |
| 3. SEX FEMALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 09 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 13a. STATE MARYLAND | | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Parsonsburg | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME ANDREW | | | 15. MOTHER'S MAIDEN NAME SARAH COX | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-14 4688 | | 17. INFORMANT Robert P. NORMAN | |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Arrest, shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis - Coronary</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Diabetes mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>87</u> to <u>5/22</u> , 19 <u>87</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Blaggar</u> | | DEGREE MD | | 22c. DATE SIGNED 5/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Deepak Saggan | | 22e. ADDRESS 547 Riversidedn Salisbury, MD, 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/26/1987 | 23c. NAME OF CEMETERY OR CREMATORY Jerusalem Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parsonsburg Wil. MD. |
| 24. FUNERAL DIRECTOR BAKER & BOUND | | ADDRESS Salisbury, MD 21801 | | 25a. DATE RECEIVED BY REGISTRAR MAY 28 1987 | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

2010-11-16

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 15561

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | |
| Myrtle Georgia Norweck | | | MONTH DAY YEAR | | | MONTH DAY YEAR | | | MONTH DAY YEAR | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | |
| Female | | | White | | | 12 12 99 | | | 87 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore, Md. | | | U.S.A. | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Wicomico MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | | Peninsula General Hospital | | | Housewife | | | Own Home | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Wicomico | | | Salisbury | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | |
| August J. Regner | | | Mary Hofstetter | | | No | | | 215-01-0043 | | |
| 17a. STREET ADDRESS | | | 17b. ADDRESS | | | 17c. ADDRESS | | | 17d. ADDRESS | | |
| Civic Ave. & Rt. 50 | | | 228 Canal Park Dr | | | Salisbury, Md. | | | 21801 | | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | 72 hours | |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) Chronic Atrial Fibrillation | | years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) Arteriosclerotic Heart Disease | | years | |

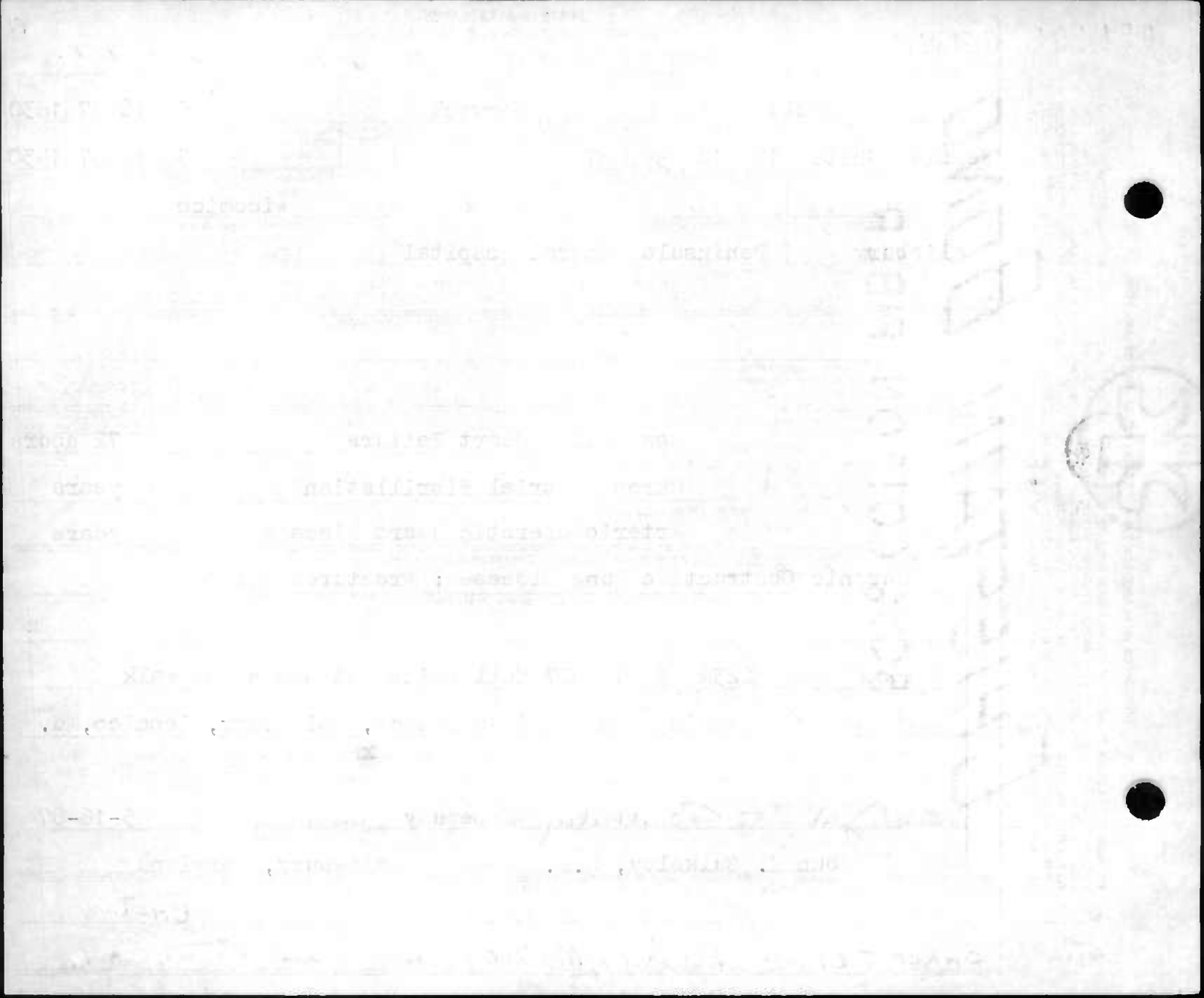
| | | | |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | |
| Chronic Obstructive Lung Disease ; Fractured Pelvis | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 20b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | |
| | | 2230 M. 5 10 19 87 | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| | | Nursing Home | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. LOCATION | |
| fell while attempting to walk | | Civic Avenue, Salisbury, Wicomico, Md. | |

| | | | |
|--|--|------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | |
| John T. Bulkeley | | Deputy | |
| EXAMINER'S NAME (TYPE OR PRINT) | | DATE SIGNED | |
| John T. Bulkeley, M.D. | | 5-16-87 | |
| ADDRESS | | MEDICAL EXAMINER | |
| Salisbury, Maryland | | | |

| | | | | | | | | | | | |
|---|--|-----------|--|------------------------------------|--|------------------------------|--|----------------------------|--|------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN) | | 23e. COUNTY | | 23f. STATE | |
| Burial | | 5/19/87 | | Oak Lawn Cemetery | | Baltimore | | BALT. | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| BAKER + BAKER | | | | MAY 20 1987 | | | | A. J. ... | | | |
| NAME ADDRESS | | | | SALISBURY, MD 21801 | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM 100-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



052798

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15508

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ODELL Owens | | 2a. DATE OF DEATH MONTH DAY YEAR May 5, 1987 | | 2b. HOUR 2:19 M |
| 3. SEX Female | 4. RACE Blk | 5. DATE OF BIRTH MONTH DAY YEAR 12 24 65 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Barnwell S.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SALISBURY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer | |
| 13a. STATE Md. | | 13b. COUNTY Wico. | 13c. CITY OR TOWN Fruitland | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ephraim Hunter | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace William | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO 213-22-6555 | | |
| 17. INFORMANT Ollie Mae Carter | | ADDRESS 302 Elizabeth Street - Fruitland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 4 , 19 87 , to MAY 5 , 19 87 , that (I) (we) last saw the deceased alive on MAY 5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Paul R Fleury | | DEGREE MD | | 22c. DATE SIGNED 5/5/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL R Fleury | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-9-87 | 23c. NAME OF CEMETERY OR CREMATORY St. John Bapt. Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Barnwell S.C. |
| 24. FUNERAL DIRECTOR NAME Levi's Watson | | ADDRESS A. E. Ward R/H Salisbury, Md. 21807 | | 25. DATE REC'D. BY REGISTRAR MAY 7 - 1987 |

MEDICAL CERTIFICATION

021546

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53665 MAY 1987

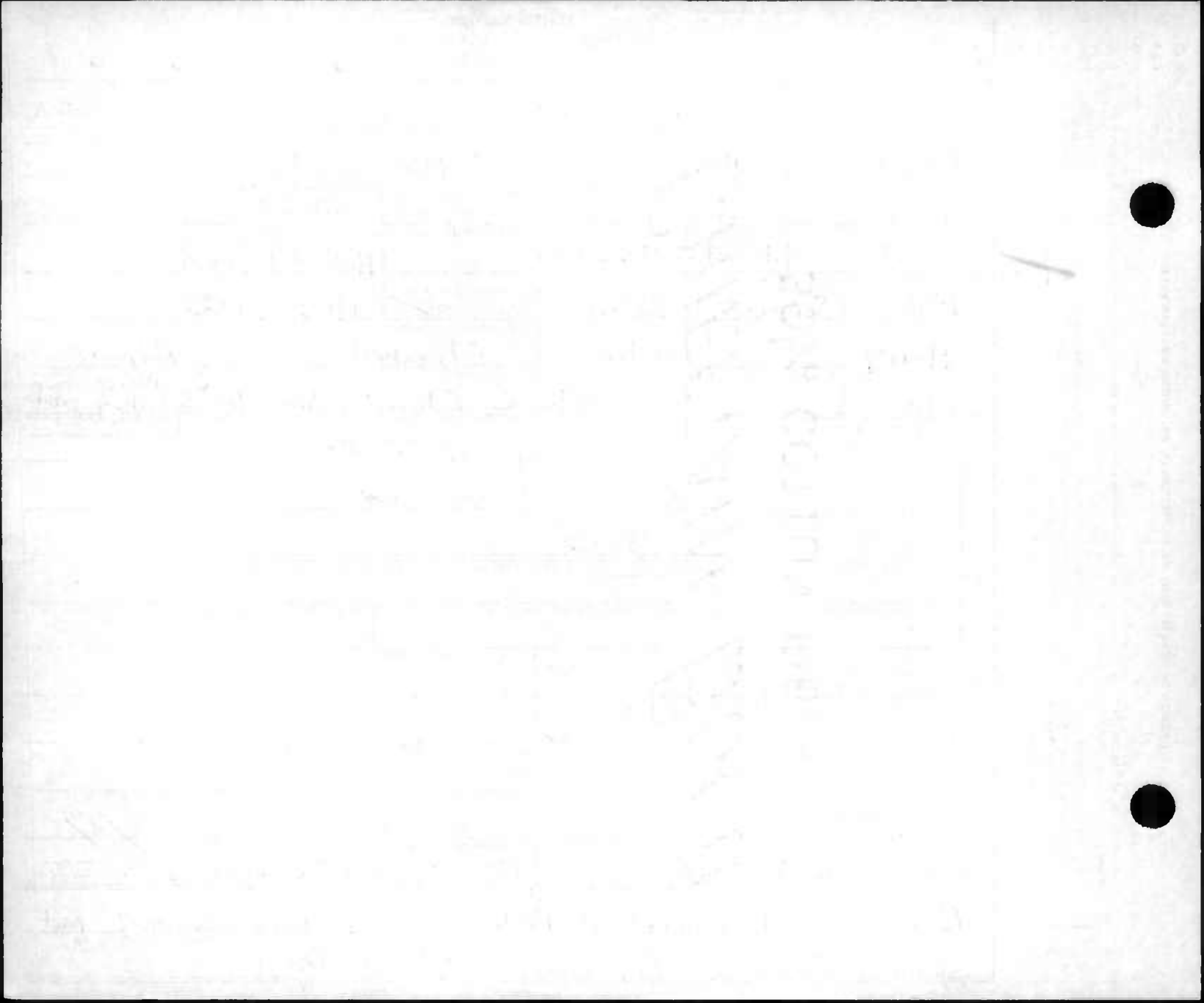
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|---------------------------|---|--|--|---------------------------|--|---|--|--|
| FOR STATE REGISTRAR | | | | | 87 REG. NO. 15569 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES E. PALMER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 10 87 2b. HOUR 5:20 AM | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 08 15 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD | | | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Eden | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Palmer | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Palmer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-07-1636 | | 17. INFORMANT ADDRESS C. Edward Palmer Jr 611 Manor Drive Salisbury, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SENILE DEMENTIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH P 1 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/9/87</u> to <u>5/10/87</u> , that (I) (we) last saw the deceased alive on <u>5/9/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>William H. Robins</u> | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>5/14/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. ROBINS M.D. | | | | | | 22e. ADDRESS CIVIC AVE & RT. 50, SALISBURY, MD. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE May 11, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY St Andrew | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pr Anne Somerset Md | | | |
| 24. FUNERAL DIRECTOR NAME James J. Hummer | | | | | | ADDRESS B. Anne, Md | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1987 | | 25b. REGISTRAR'S SIGNATURE | |



055519 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifies that the death certificate was executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be filed with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked for item 18, a copy of the death certificate should be filed with the State Dept. of Health and Mental Hygiene.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|--|
| <div style="text-align: right;">REG. NO. 87-15570</div> | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN W. PAYNE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1987 | | 2b. HOUR 2210 M | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE route 2, box 401 21851 | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Payne | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ocea Aydolette Pilchard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 217-36-0256 | | | 17. INFORMANT John H. Payne, Pocomoke City, Md. 21851 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Carcinoma of the lung</i> DUE TO, OR AS A CONSEQUENCE OF (b): <i>Advanced Chronic obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c): <i>Pulmonary Embolus</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/25</i> 19 <i>87</i> , to <i>5/21</i> 19 <i>87</i> , that (I/we) last saw the deceased alive on <i>5/21</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Helen M. Baldoda</i> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HELEN M. BALDODA | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Remson Meth. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Scott S. Melen</i> Pocomoke City, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia K. ...</i> | | | |

BP

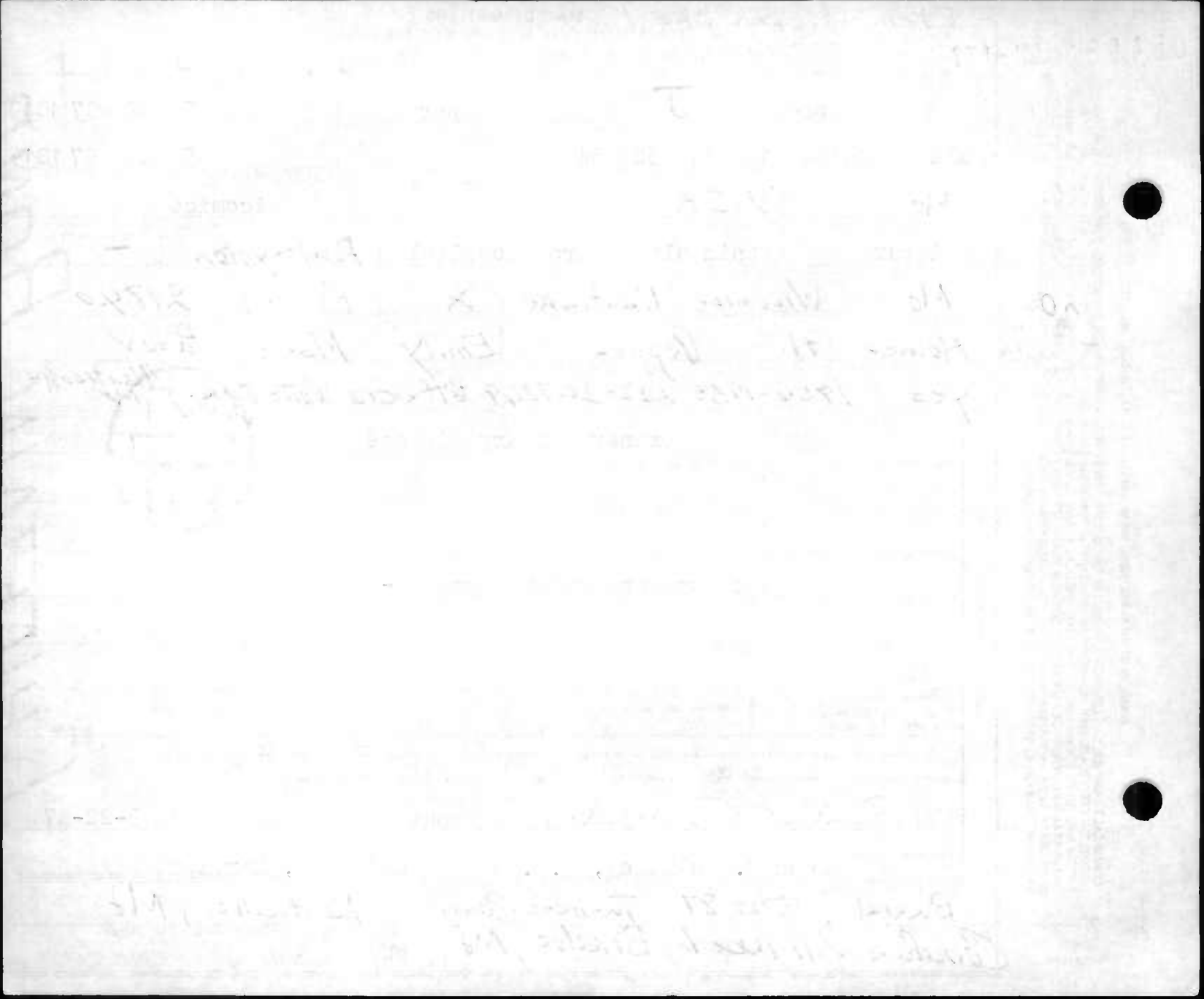
Helen M. Balgola

054938 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES AND SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF RECORDS, 601 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| Item 13e per phone | | | | | | | | | |
| FOR STATE REGISTRAR | | | | | | | | | |
| 6/2/87 DAD | | | | | | | | | |
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 5571 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hance J. Pepper | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 22 1987 | | | | | | | | | |
| 2b. HOUR 1818 | | | | | | | | | |
| 3. SEX Male | | | | | | | | | |
| 4. RACE White | | | | | | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR 10 14 32 | | | | | | | | | |
| 6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK (MOST OF WORKING LIFE) Poultryman | | | | | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY - | | | | | | | | | |
| 13a. COUNTY Wicomico | | | | | | | | | |
| 13b. CITY OR TOWN Nanticoke | | | | | | | | | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 13d. STREET ADDRESS Rural 21840 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Homex H. Pepper | | | | | | | | | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Marie Pasex | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. 1954-1956 222-20-7249 | | | | | | | | | |
| 17. INFORMANT ADDRESS Betty White Roper, Nanticoke, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Post Coronary Artery Bypass - 1982 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE John T. Bulkeley M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 5-22-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D. ADDRESS Salisbury, Maryland | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | |
| 23b. DATE 5/27/87 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Turners Comm. | | | | | | | | | |
| 23d. LOCATION (CITY OR TOWN) Nanticoke, Md. COUNTY STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Thomas D. W. Pasex, Bivertown, Md. | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR MAY 28 1987 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | |



054886 JUN 1

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

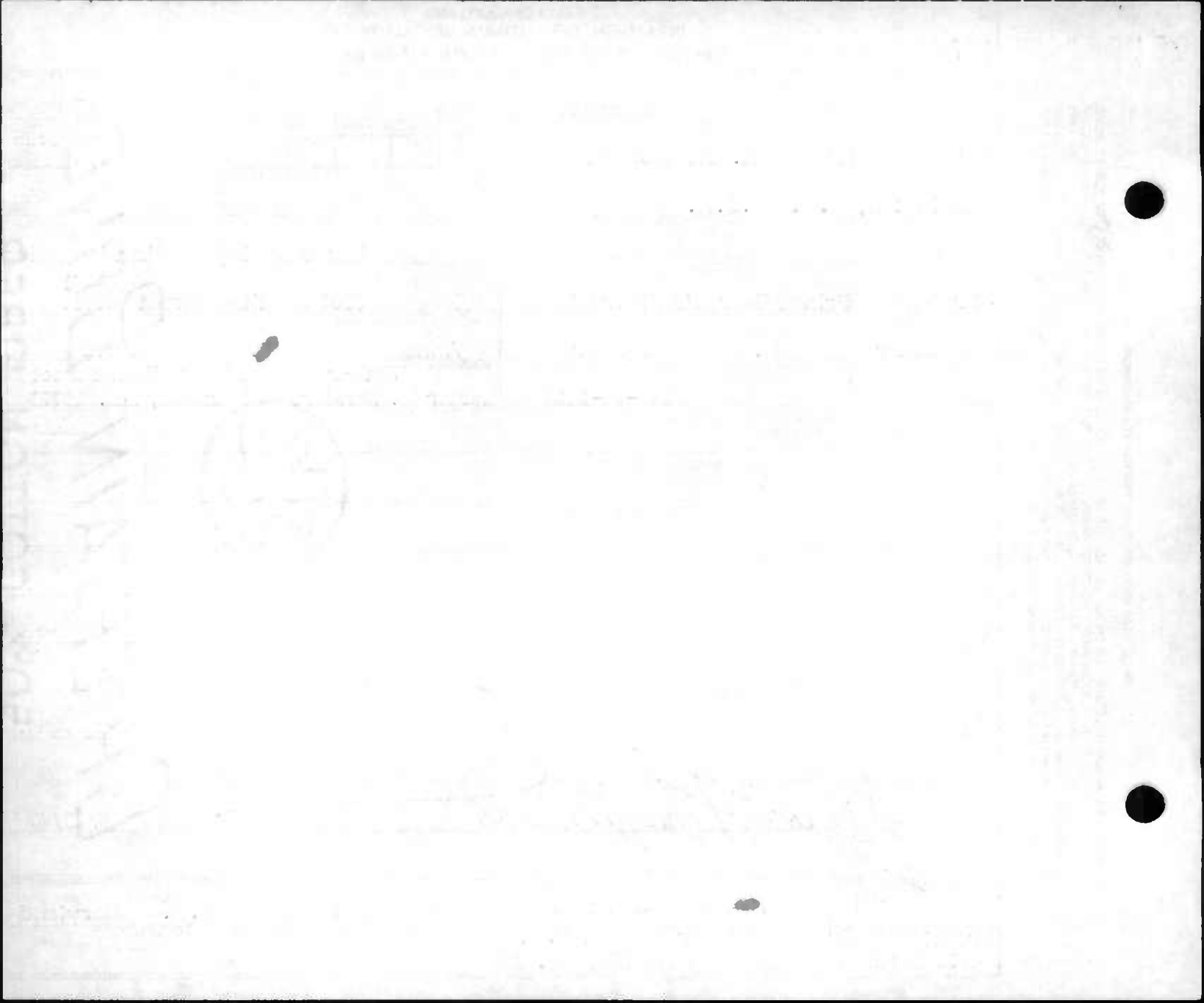
REG. NO. 5572

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|----------------------------|--|-------|--|------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | HOUR | |
| Joseph Lawrence Sanders | | | | | | | | 5/ 24/ 19 87 | | | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | Oct. 21, 1956 | | 30 YRS. | | | | | | 5/ 24/ 19 87 | | | | | | a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD | |
| Washington, D.C. | | U.S.A. | | | | | | Wicomico County, | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Salisbury | | Peninsula General Hospital | | Landscapping | | Landscapping | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Prince George's | | Riverdale | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6701 Hamilton Street | | 20737 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Lester M. Sanders | | Anne D. E. Evans | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Father) | | ADDRESS | | | | | | | | | | | |
| No | | 212-64-9421 | | Lester M. Sanders | | 6701 Hamilton Street | | Riverdale, Md. | | 20737 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Blunt Head Trauma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 2:40 PM 5/24/ 19 87 | | driver of auto/lost control/hit ditch | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | roadway | | Rt. #50 & Riggins Rd., Mardela, Wic. Co., Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant MEDICAL EXAMINER | | 5/25/87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| 133 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | | | | | | | |
| Burial | | 05/24/87 | | Cedar Hill Cemetery | | Suitland | | MAY 28 1987 | | Julia Sanders | | | | | | | |
| 23g. FUNERAL DIRECTOR | | 23h. ADDRESS | | | | | | | | | | | | | | | |
| Francis Gasch's Sons Funeral Home, P.A. | | 4739 Baltimore Avenue Hyattsville, Md. 20781 | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10A. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M
 BP
 DHMH - 17
 (VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15573

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT Stanley SCHILLING Jr | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 2, 1987 | | 2b. HOUR 4:45 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1959 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 27 | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Wicomico Hebron | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS - ZIP CODE Box 8895 21830 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT S. Schilling | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VALERIE ANN ZVEREV | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 212-78-4974 | | 17. INFORMANT ADDRESS Robert S. Schilling Box 8895, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Palsy DUE TO, OR AS A CONSEQUENCE OF (c) | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5/2 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Salisbury MD | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2 19 87 to 5/2 19 87 that (I) (we) last saw the deceased alive on 5/2 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE D. O. L. L. | | DEGREE M.D. | | 22c. DATE SIGNED 5-2-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David E. Connell, M.D. | | 22e. ADDRESS 148 E. Carroll St Salisbury MD 21807 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 5/4/1987 | | 23c. NAME OF CEMETERY OR CREMATORY DeMarva Crematory LEWIS | |
| 24. FUNERAL DIRECTOR Baker & Bards, Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 5 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Henderson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be obtained.

THE RECORD



THE RECORD
OF THE
PROCEEDINGS OF THE
COUNCIL OF THE
CITY OF BOSTON
IN THE
YEAR 1888
PUBLISHED BY THE
CITY OF BOSTON
1889

055700 JUN 5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15574

| | | | | | |
|--|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) George Herbert Semblly | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1987 | | 2b. HOUR 0953 M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7-22-1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Semblly | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-44-5888 | | 17. INFORMANT ADDRESS Elizabeth C. Cordery 1802 Sommers Dr. Salis. Md 21801 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ruptured abdominal aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>known abdominal aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>several years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>two hours</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION May 29, 1987 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aneurysm | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> , 19 <u>87</u> , to <u>5/29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Michael P. Buchness M.D. | | DEGREE | | 22c. DATE SIGNED 5/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Buchness | | 22e. ADDRESS Medical Center West, Salisbury Md 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN ACRES | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wico Md | | | | | |
| 24. FUNERAL DIRECTOR NAME Gladys B. Stewart | | ADDRESS West Rd Salis. Md | | 25a. DATE RECEIVED BY REGISTRAR JUN 5 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia D. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

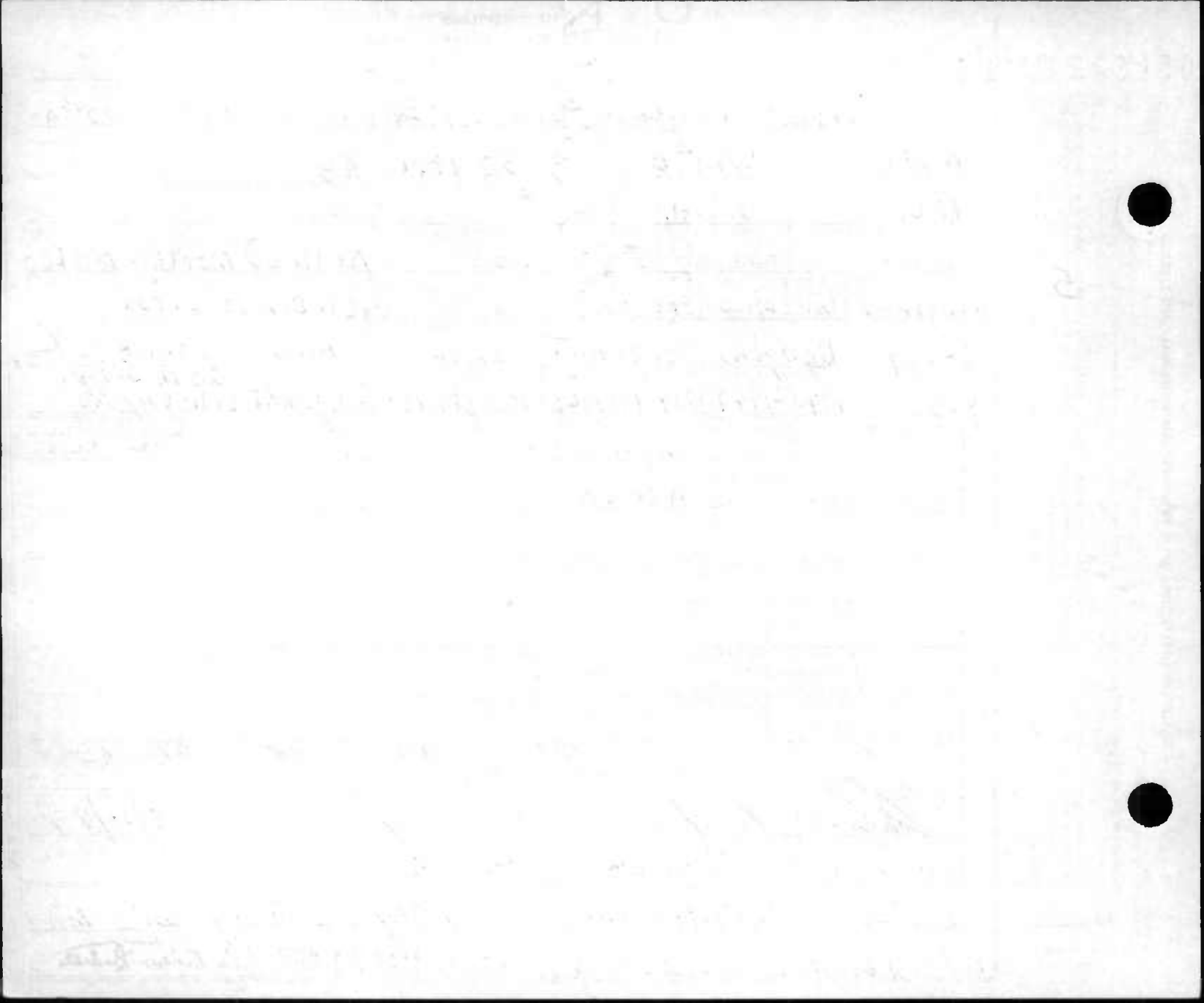
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15575

| | | | | | | | |
|---|--|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| CHARLES DOUGLAS | | Sergeant SN | | May 20, 1987 | | 1246 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| MALE | white | 3 30 1907 | | 80 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MD. | |
| N.C. | U.S.A. | | | Wicomico | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | Peninsula General Hospital | | Retired Mortgage Broker | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | |
| Maryland | | Wicomico | Salisbury | | 320 N. Div. St. 21801 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| LACEY | | DoUGLAS | | Lael ANN Starbuck | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| yes | | 1942-1947 | | Josephine C. Sergeant 320 N. Div. St. Salisbury, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) myocardial infarction | | | | | | | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) ASCVD | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/15, 1987, to 5/20, 1987, that (I) (we) lost saw the deceased alive on 5/20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Charles B. Silvia Jr MD | | | | MD | | 5/20/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Charles B. Silvia Jr MD | | | | PGH MC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 5/22/1987 | | PARSONS Cemetery | | SALISBURY Wic MD | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| BAKER & BOUNDS | | | | MAY 21 1987 | | Julia Davidson-Rudner | |

BP



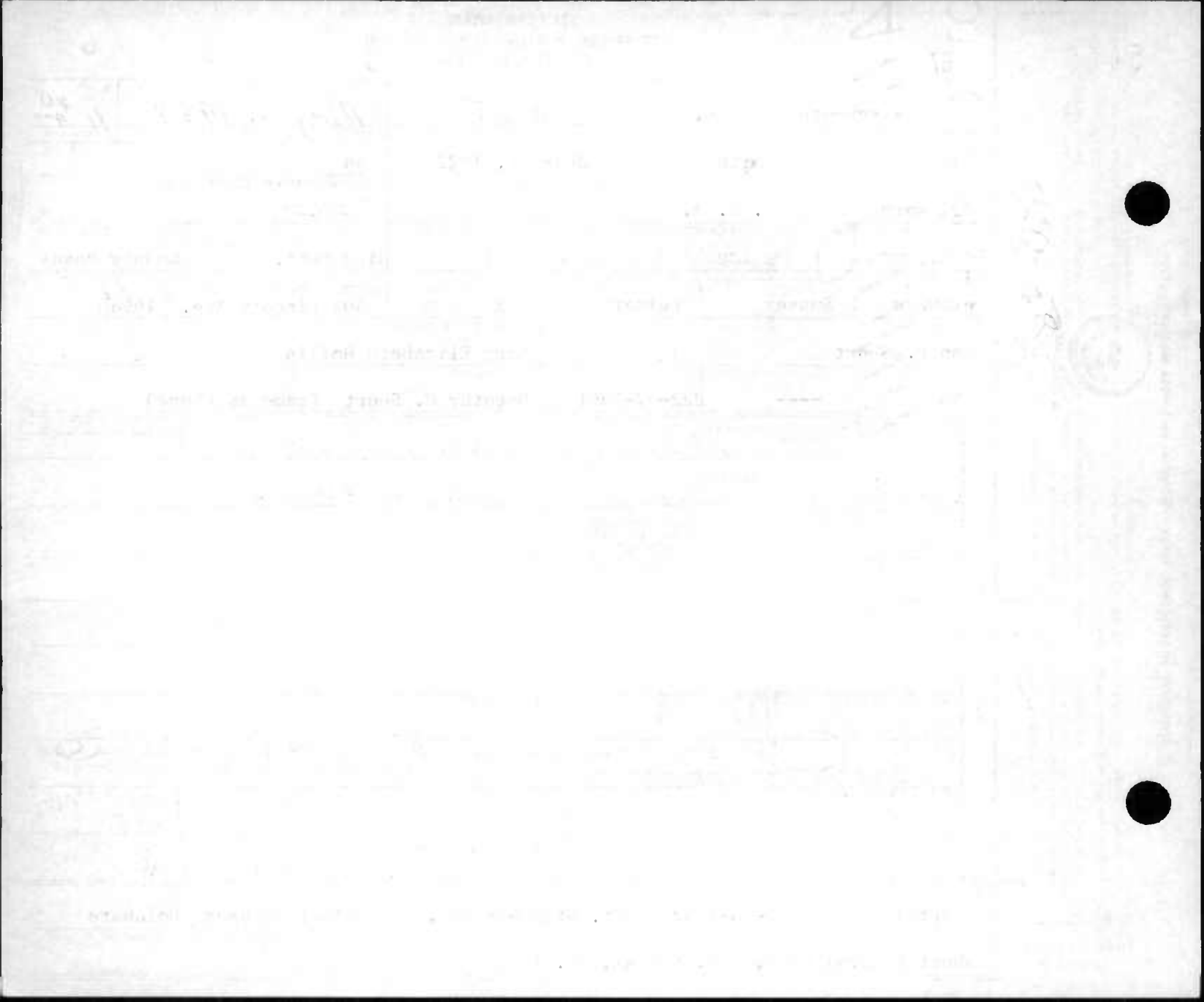
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15576
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kenneth H. Short | | | 2a. DATE OF DEATH MONTH DAY YEAR May 21, 1987 | | | 2b. HOUR 11:40 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 18, 1922 | | 6. AGE (IN YEARS: LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sign Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY County Roads | |
| 13a. STATE Delaware | | | 13b. COUNTY Sussex | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leon D. Short | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Hollis | | | 13e. STREET ADDRESS / ZIP CODE 502 Lincoln Ave. 19940 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS Dorothy C. Short (same as above) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Violence</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>11a</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 19 <u>87</u> , to <u>5/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>5/21/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J A Cockley, M.D.</u> | | | | | 22e. ADDRESS <u>108 Sower St Salisbury, Md 21801</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-24-1987 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Delaware | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Short Funeral Home, Inc. Delmar, DE. 19940 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 28 1987 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the body must be autopsied within 24 hours after death. Page 4 may be retained by the funeral director, page 3 should be filed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

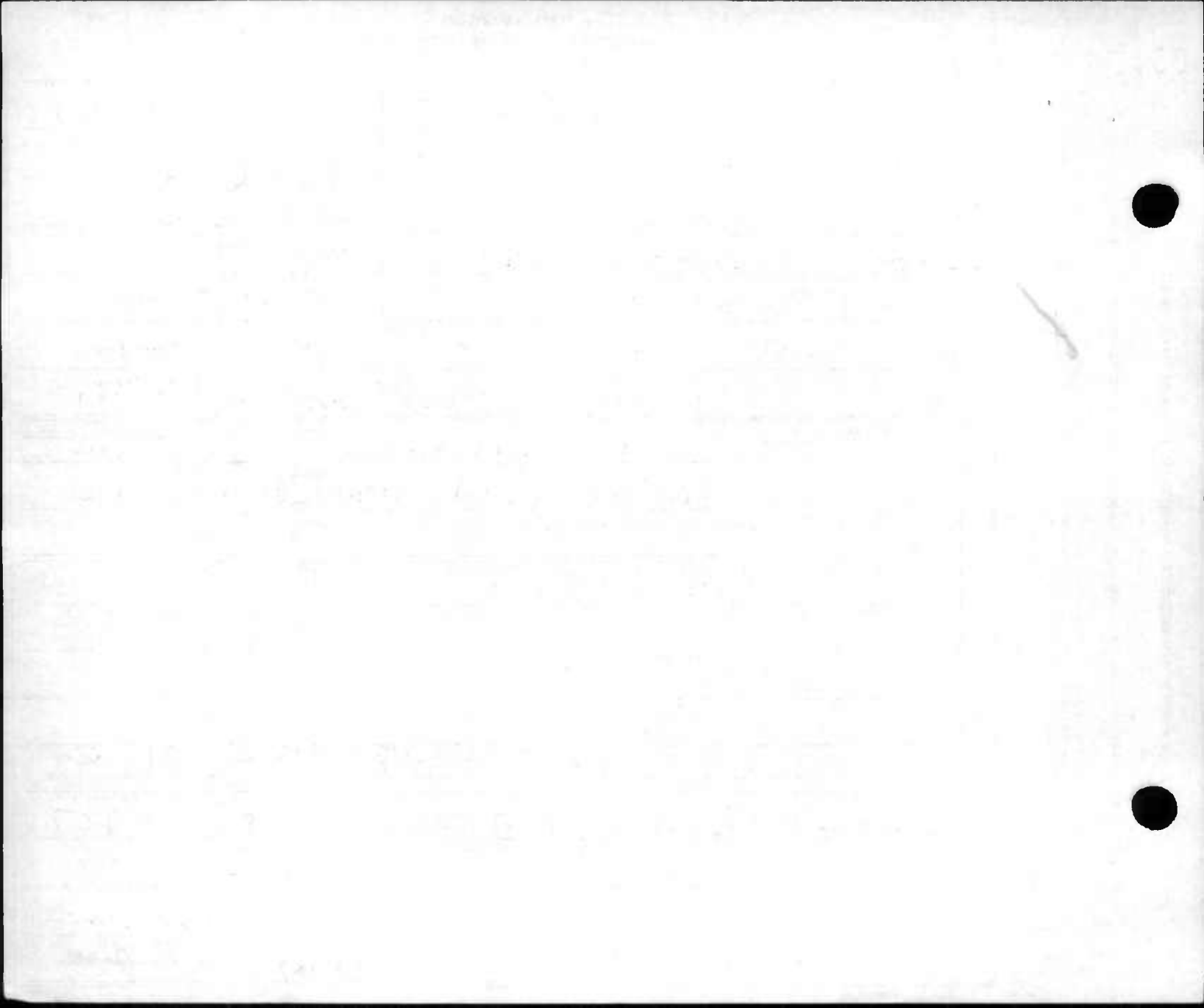
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MAGE MIDDLE Robertson LAST Smith | | MAY 9, 1987 | | 0818 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR 01 26 1921 | 66 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | |
| Maryland | Wicomico | Salisbury | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Peninsula General Hospital | None | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | Wicomico | Tyaskin | YES <input type="checkbox"/> NO <input type="checkbox"/> | In Village 21865 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| FIRST MAGE MIDDLE Mansfield LAST Smith | FIRST Sarah MIDDLE Eliza LAST Brumley | 214-76-5600 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 17b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| No | 214-76-5600 | Mrs. Mary W. Wheatley (Sister) 418 Loblolly Lane, Salisbury, Md. 21801 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Coronary occlusion | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-1, 1987, to 5-9, 1987, that (I) (we) last saw the deceased alive on 5-9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| John G. Bulkeley | M.D. | | 5-9-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| John G. Bulkeley, M.D. | 100 Power Street, Salisbury, Md. 21801 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 5/12/1987 | Shad Point Cemetery | Salisbury, Wicomico, Maryland | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Holloway Funeral Home, P.A., Salisbury, Maryland | MAY 12 1987 | | John Davidson-Randall | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

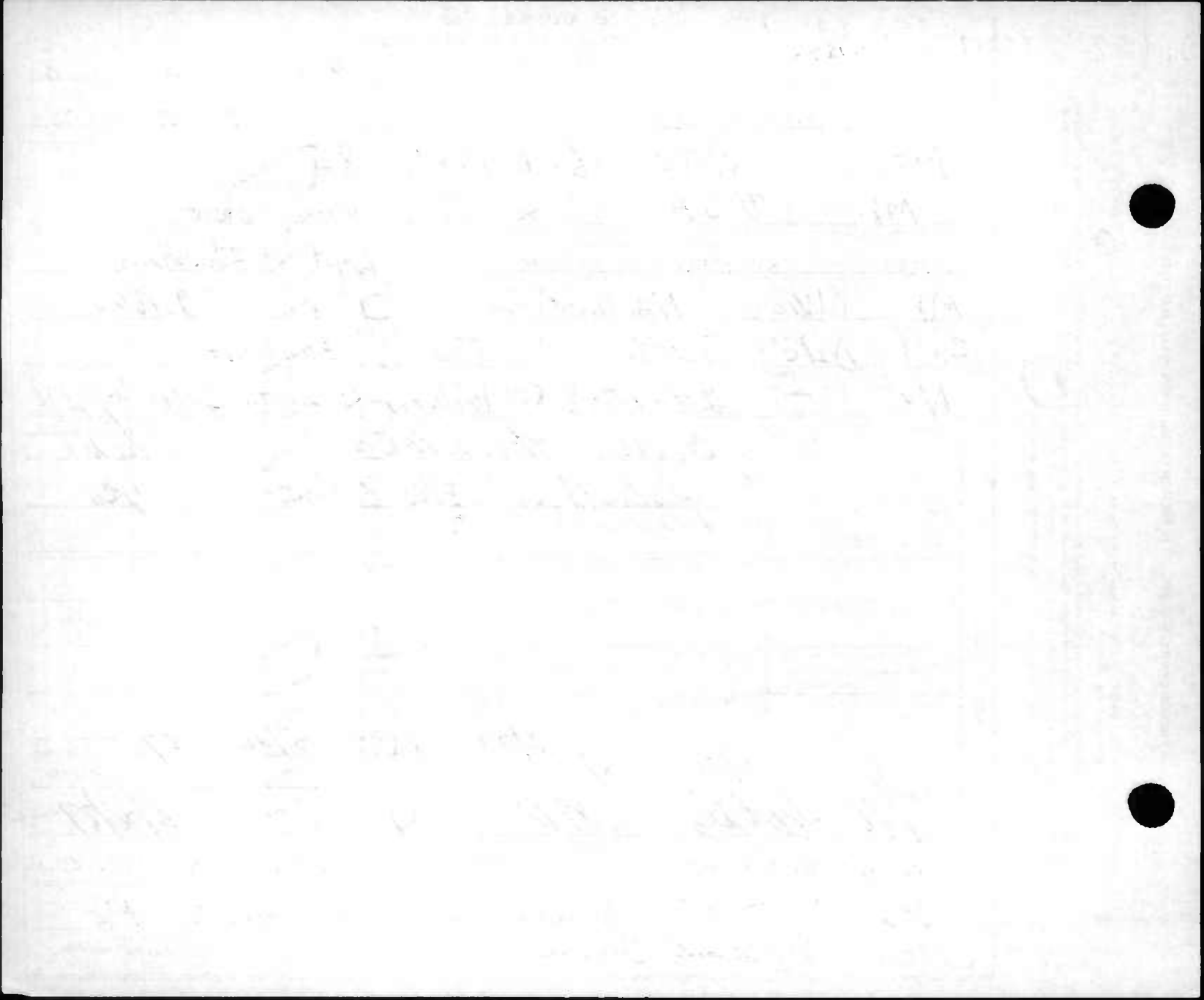
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13c per phone STATE OF MARYLAND
FOR STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR CERTIFICATE OF DEATH

87 REG. NO. 15578

| | | | | | | |
|--|------------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM D. SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-20-87 | | 2b. HOUR 4:00A M | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 6-16-1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MT. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Dept. of Education | | |
| 13a. STATE MD | | 13b. COUNTY Wic. | | 13c. CITY OR TOWN Nanticoke | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gedie Dale Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ira Hepkins | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-05-8080 | | 17. INFORMANT ADDRESS William H. Smith, Salisbury, Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF: (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. yes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19/87 to 5/20/87 , that (I) (we) last saw the deceased alive on 5/19/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Earl M. Beardsley | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | 22e. ADDRESS CIVIC AVE, & RT. 50, SALISBURY, MD. 21801 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/22/87 | | 23c. NAME OF CEMETERY OR CREMATORY Turkey Com. | | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Nanticoke, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1987 | | | | |
| 24. FUNERAL DIRECTOR Cornelius Messing | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

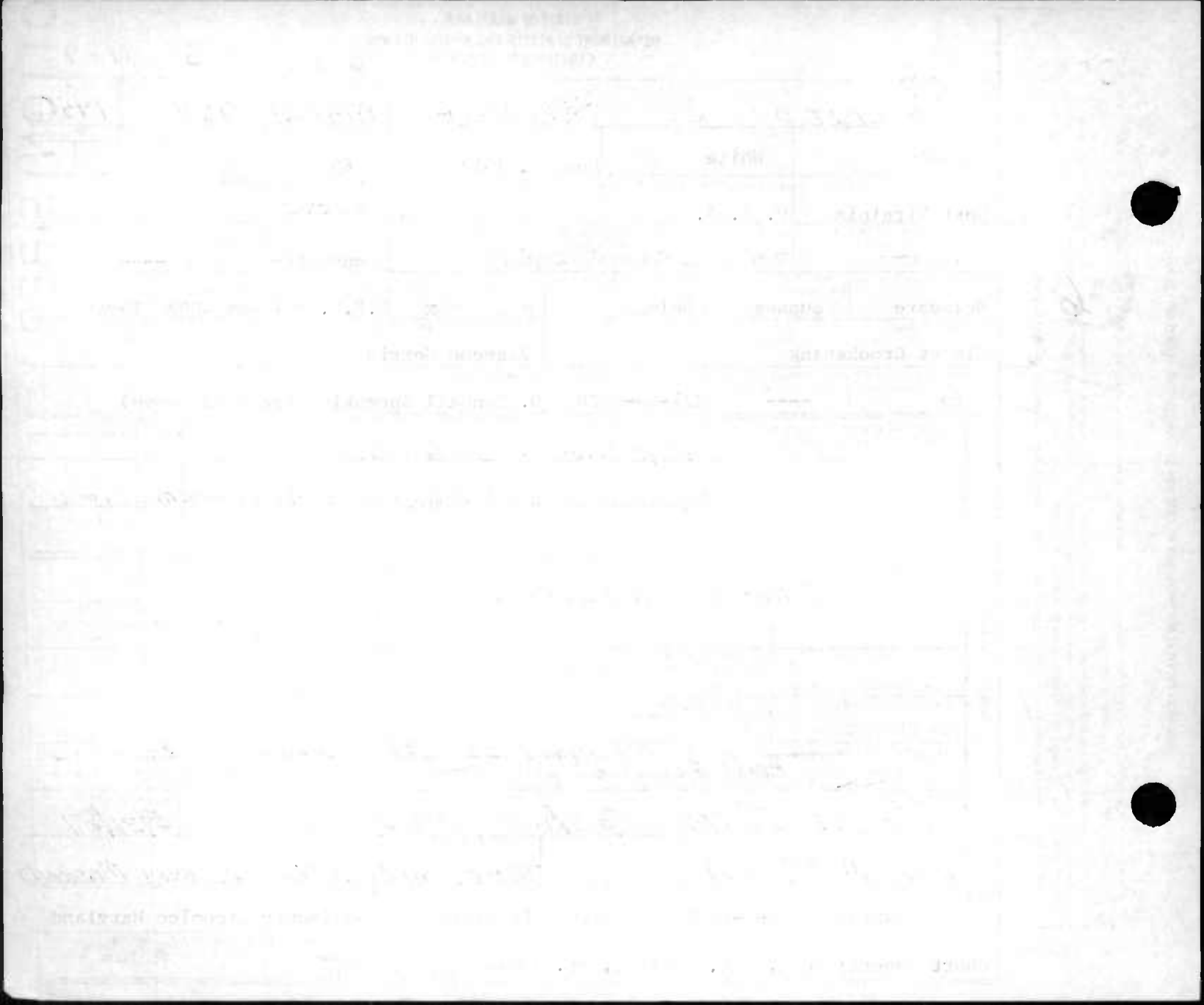
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 and file with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15579

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED C. LAST SPRENKLE | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 31, 1987 | | 2b. HOUR 1450 |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 2, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY ---- |
| 13a. STATE Delaware | | 13b. COUNTY Sussex | 13c. CITY OR TOWN Delmar | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elbert Crookshank | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Morris | | 13e. STREET ADDRESS / ZIP CODE R.F.D. # 1 Box 489A 19940 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---- | | 16b. SOCIAL SECURITY NO. 221-46-9228 | | 17. INFORMANT D. Randall Sprengle (same as above) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive and Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>DIABETES MELLITUS</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) the hospital attended the deceased from <u>April 22</u> , 19 <u>87</u> , to <u>May 31</u> , 19 <u>87</u> , that (I) have last saw the deceased alive on <u>April 21</u> , 19 <u>87</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I me we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Allen W. Tustin, M.D.</u> | | | | 22c. DATE SIGNED 5/31/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen W. Tustin</u> | | | | 22e. ADDRESS <u>7A MEDICAL CENT. No., SALISBURY, MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-3-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Short Funeral Home, Inc. Delmar, DE. 19940 | | | |
| 25a. DATE REC'D. BY REGISTRAR JUN 2 1987 | | | | 25b. REGISTRAR'S SIGNATURE <u>D. Randall Sprengle</u> | |



055224 JUN-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 15580

REG. NO.

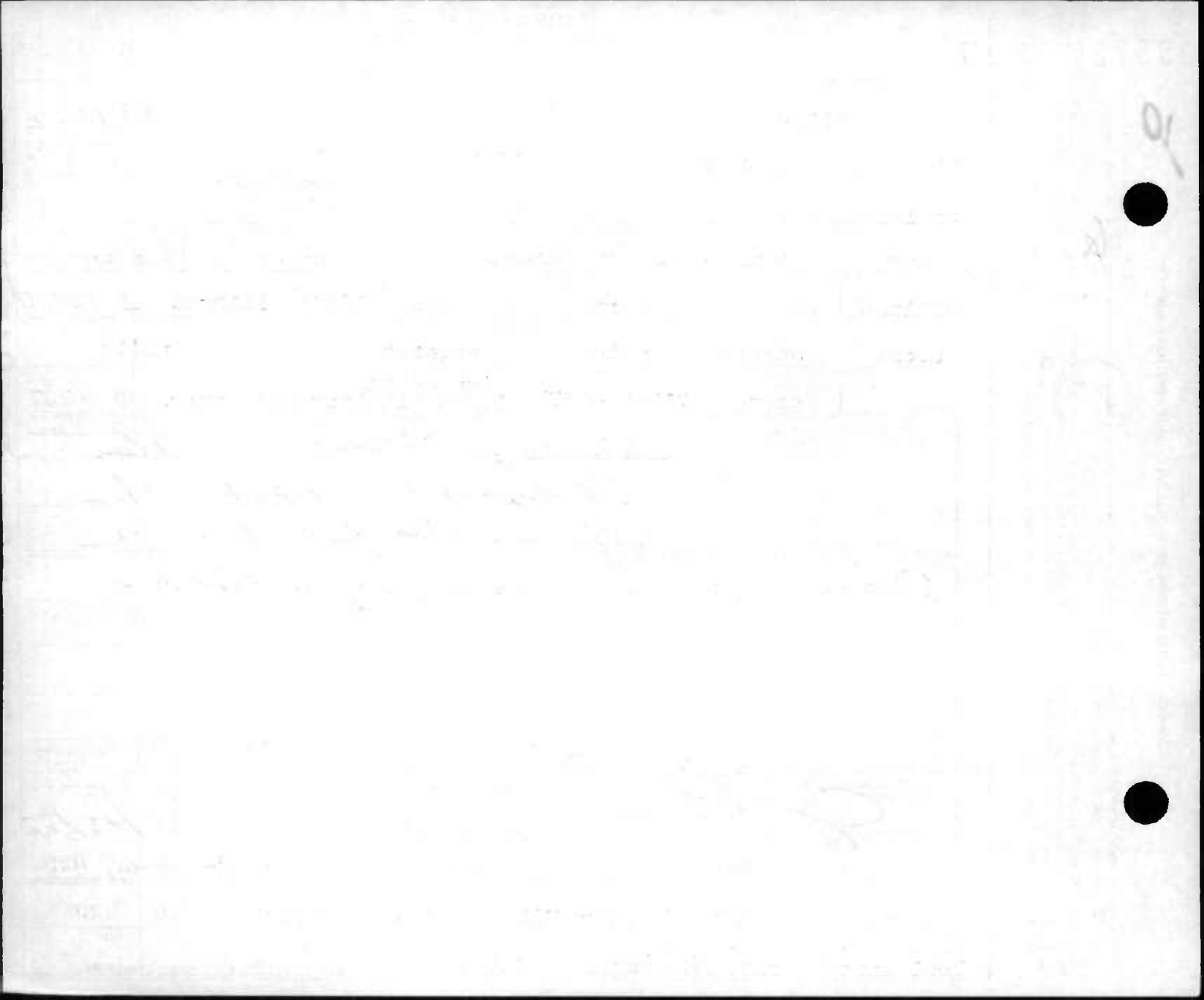
| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gerald E SUTTON | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 25 87 | | | 2b. HOUR 1300 M | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 3/15/29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | |
| 12b. KIND OF BUSINESS OR INDUSTRY Academy Ford | | 13a. STATE Maryland | | 13b. COUNTY PG | | 13c. CITY OR TOWN Laurel | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Eugene Joseph Sutton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret White | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | |
| 16b. SOCIAL SECURITY NO. 213-24-3977 | | 17. INFORMANT Nita Sutton | | ADDRESS 15643 Millbrook LA Laurel MD 20707 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (c) After self cardiac arrest | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Overexertion, fatigue, cough, etc. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/10/87 19 87 to 5/25/87 19 87 , that (I) (we) saw the deceased alive on 5/10/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Gary Green, M.D. | | | | DEGREE MD | | 22c. DATE SIGNED 5/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Gary Green, M.D. | | | | 22e. ADDRESS Eastern Shore Drive Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel PG MD | |
| 24. FUNERAL DIRECTOR Fleck Funeral Home Inc. | | | | 25. DATE REC'D. BY REGISTRAR JUN 1 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |
| 26. ADDRESS 7601 Sandy Spring Rd Laurel MD 20707 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies of pages 1, 2, and 3 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or checked, the medical examiner must be notified of the death.

BP

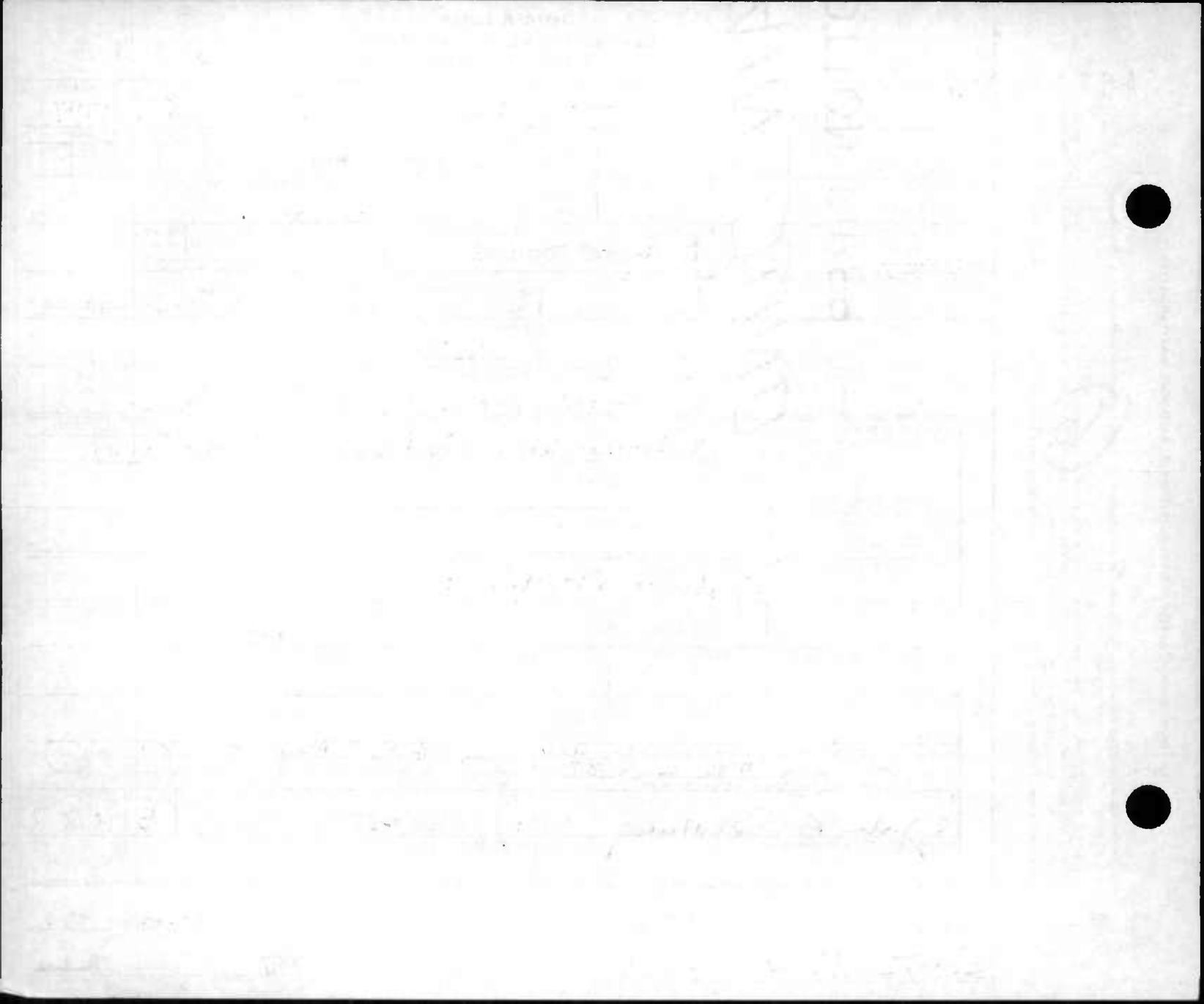


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 15581
REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|-----------------------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Grace | | MIDDLE B | | LAST Taylor | | 2a. DATE OF DEATH MONTH DAY YEAR 5 9 87 | | | | 2b. HOUR 1747 M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 8 6 15 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired practical Nurse | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Pine Bluff Village -20851- | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John W. Bloxom | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jannie -same Bull | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | | | | |
| | | 16b. SOCIAL SECURITY NO. 214-12-6527 | | 17. INFORMANT ADDRESS Route #3, Box 139A Jack T. Taylor Easton, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (yr) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes Mellitus</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Aug 19 63</u> to <u>May 9 19 87</u> that (1) (we) last saw the deceased alive on <u>May 2 19 87</u> , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John F. G. Bullock</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5-10-87 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY Downing's Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Oak Hall Accomack Va. | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Scott S. Nelson</u> | | ADDRESS Pocomoke City, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodack</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

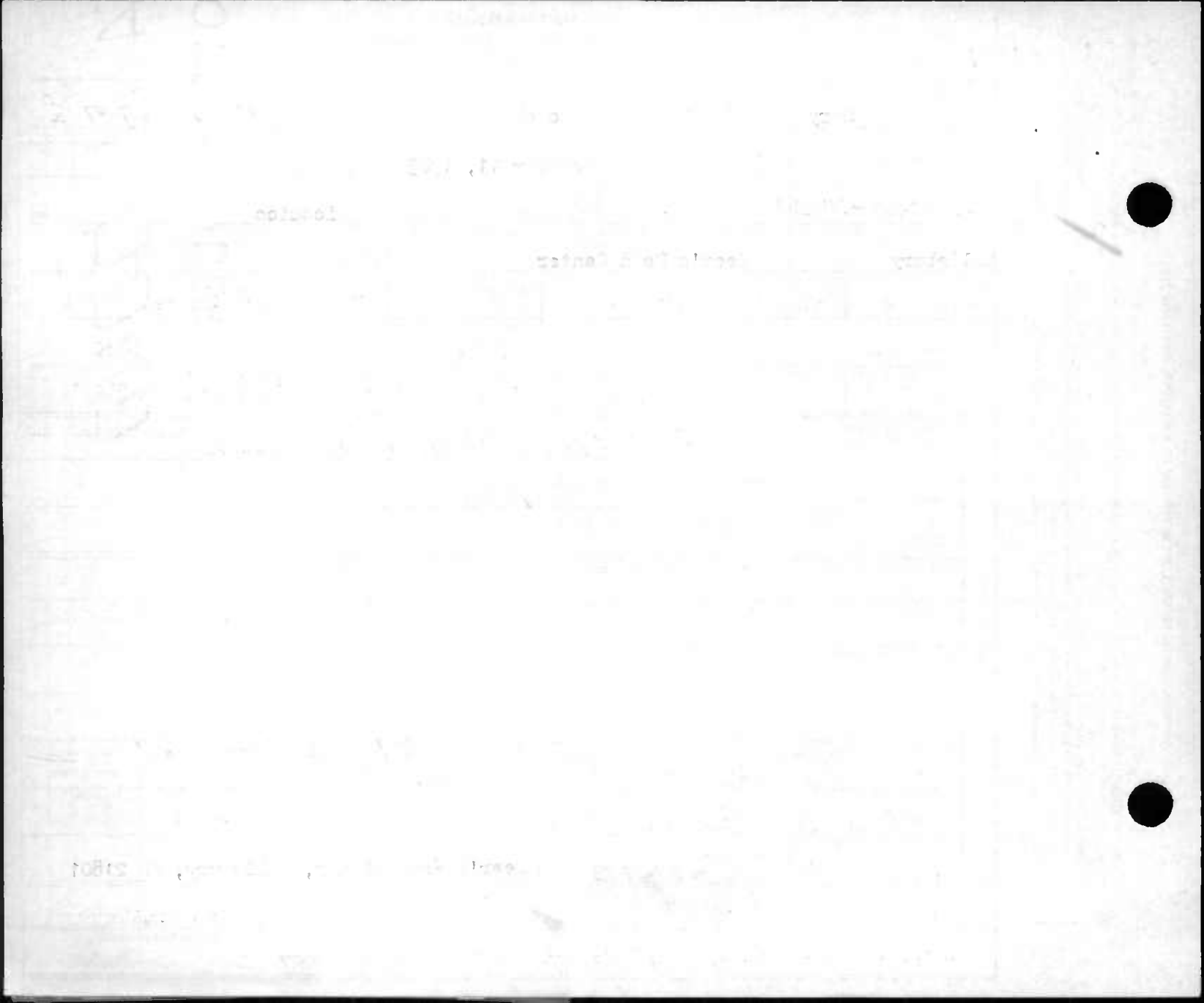
IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 15582

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Virginia Toach | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 12 87 | | | | 2b. HOUR 7 30 A.M. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 11, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chincoteague, Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Laundry | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 514J Georgia Avenue 21801 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Littleton Townsend | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Cluff | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 214-10-9043 | | 17 INFORMANT Joyce S. Bounds (Neice) | | | | 17 ADDRESS 514J Georgia Avenue, Salisbury, Md. 21801 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) End Stage Renal Disease DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1 , 19 87 , to 5-12 , 19 87 , that (I) (we) last saw the deceased alive on 5-12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Elsa M. Goris M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELSA M. GORIS | | | | 22e. ADDRESS Deer's Head Center, Salisbury, MD 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/14/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAY 15 1987 | | 25b. REGISTRAR'S SIGNATURE Anderson-Randall | | | |

BP



054158 MAY 1987

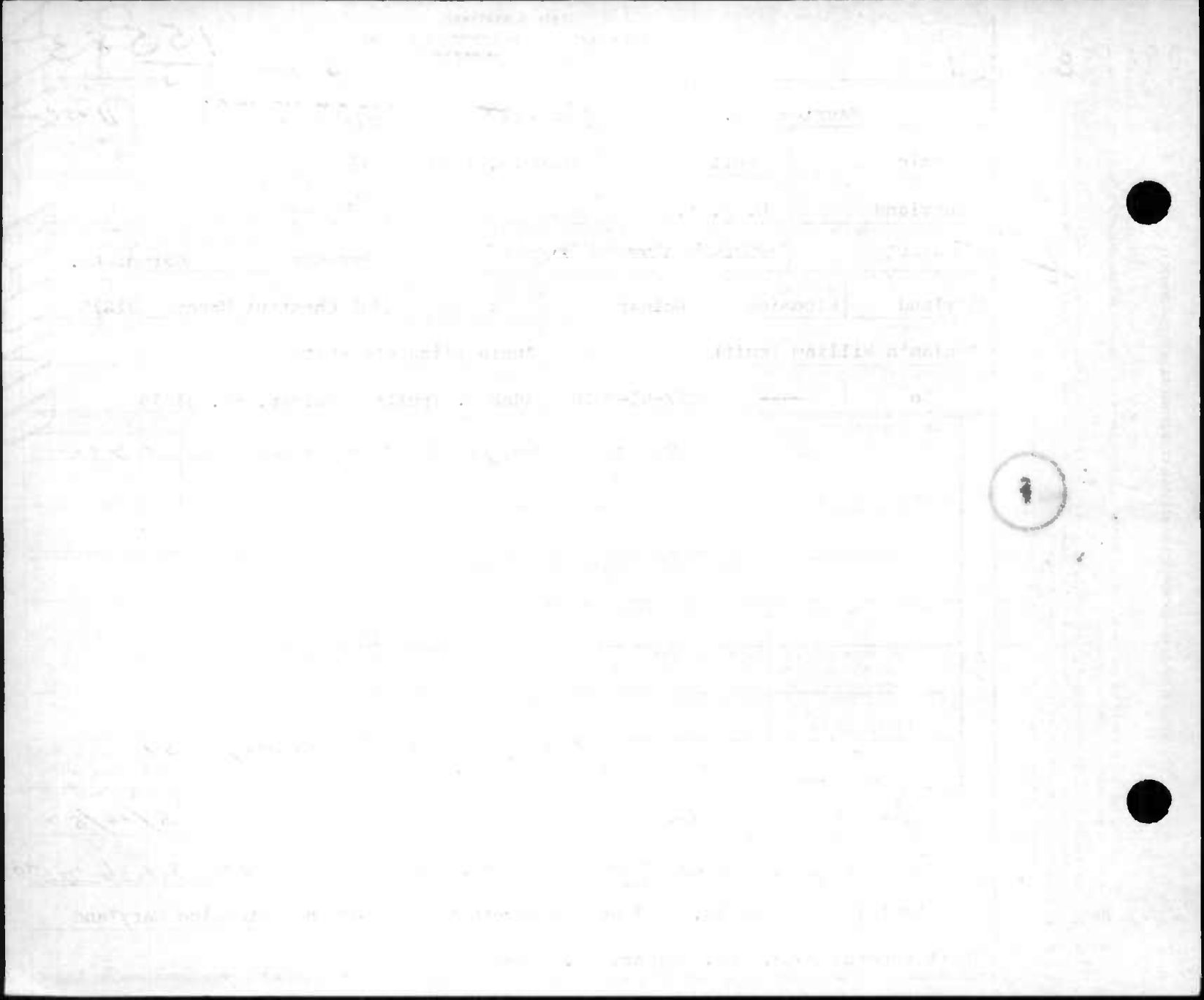
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15583

8 REG. NO. 15583

| | | | | | | | |
|--|--|--|--|---|-------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maurice L. TRUITT | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 15, 1987 | | 2b. HOUR 11:45 P.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 16, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser | | 12b. KIND OF BUSINESS OR INDUSTRY Garnet Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 206 Chestnut Manor 21875 | | 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin William Truitt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth White | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-01-8018 | | 17. INFORMANT ADDRESS Adah P. Truitt Delmar, Md. 21875 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Large Cell Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that the (this hospital) attended the deceased from <u>9 May</u> , 19 <u>87</u> , to <u>15 May</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>15 May</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>James E. Martin</i> M.D. | | | | 22c. DATE SIGNED 5/16/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Martin, M.D. | | | | 22e. ADDRESS 145 E. Carroll St., Salisbury, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE May 19, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wicomico Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Short Funeral Home, Inc. Delmar, DE. 19940 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1987 | | 25b. REGISTRAR'S SIGNATURE <i>John F. ...</i> | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15584

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys Gaines Vandegrift | | | 2a. DATE OF DEATH MONTH DAY YEAR May 13, 1987 | | 2b. HOUR 0530 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 07 24 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY Sandwich Shop | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware | | 13b. COUNTY Sussex | 13c. CITY OR TOWN Lewes | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE R.D. 1 Box 105 Sweet Briar Pk. 19958 |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Applebury Payne | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Hesteleau | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 198-12-6313-A | | 17. INFORMANT Louise Hansen | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1 19 87, to 5-13 19 87 that (I) (we) last saw the deceased alive on 5-12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE E Kent Carney | | DEGREE MD | | 22c. DATE SIGNED 5-13-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E KENT CARNEY | | 22e. ADDRESS MEDICAL CENTER PINE BLUFF ROAD SALISBURY MD 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE May 14, 1987 | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex DE | |
| 24. FUNERAL DIRECTOR NAME F. Short Funeral Home | | ADDRESS Delmar, Delaware | | 25a. DATE REC'D BY REGISTRAR MAY 18 1987 | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall |

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54271 MAY 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15585

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|---|--|--|---------|--|--|------------------|--|--|-------------------|---|--|----------------|--|--|--------------------------------------|--|--|--------------------------|--|---|----------|--|--|--|-----------------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2c. DATE PRONOUNCED DEAD | | | | | | | | | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frank A Widdowson | | | | | | | | | | 5 11 1987 | | | | | | | | | | 2245 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | | 7c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | | White | | | 4 1 21 | | | 66 | | | MONTHS | | | DAYS | | | 5 11 1987 | | | 2245 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Md | | | | | U.S. | | | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | Wicomico | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Salisbury | | | | | Peninsula General Hospital | | | | | | | | | | Farmer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | |
| Md | | | | | | | | | | Somerset | | | | | | | | | | Pr. Anne | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | Rt 2, Box 305 21853 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | 16. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Guy A. Widdowson | | | | | | | | | | Grace McMillen | | | | | | | | | | 216-18-8072 | | | | | | | | | | Betty Widdowson | | | | | | | | | | Rt 2, Box 305 Pr. Anne, Md 21853 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | 19. DATE OF OPERATION | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. LOCATION | | | | | | | | | | 21d. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | | CITY OR TOWN | | | | | | | | | | COUNTY | | | | | | | | | | STATE | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | 21g. INJURY OCCURRED | | | | | | | | | | 21h. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | STREET | | | | | | | | | | CITY OR TOWN | | | | | | | | | | COUNTY | | | | | | | | | | STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | | | | | | | | | 22b. TIME OF INJURY | | | | | | | | | | 22c. LOCATION | | | | | | | | | | 22d. INJURY OCCURRED | | | | | | | | | | 22e. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | 22f. TIME OF INJURY | | | | | | | | | | 22g. LOCATION | | | | | | | | | | 22h. INJURY OCCURRED | | | | | | | | | | 22i. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | 22j. TIME OF INJURY | | | | | | | | | | 22k. LOCATION | | | | | | | | | | 22l. INJURY OCCURRED | | | | | | | | | | 22m. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | 22n. INJURY OCCURRED | | | | | | | | | | 22o. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| John T. Bulkeley | | | | | | | | | | Deputy | | | | | | | | | | 5-12-87 | | | | | | | | | | 22p. INJURY OCCURRED | | | | | | | | | | 22q. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | 22r. INJURY OCCURRED | | | | | | | | | | 22s. INJURY OCCURRED | | | | | | | | | | 22t. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| John T. Bulkeley, M.D. | | | | | | | | | | Salisbury, Maryland | | | | | | | | | | 22u. INJURY OCCURRED | | | | | | | | | | 22v. INJURY OCCURRED | | | | | | | | | | 22w. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | | | | | | | | 23e. LOCATION | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | May 15, 1987 | | | | | | | | | | Evergreen | | | | | | | | | | Berlin | | | | | | | | | | Worcester | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 24a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | 24c. REGISTRAR'S SIGNATURE | | | | | | | | | | 24d. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| James L. Hinson | | | | | | | | | | May 21 1987 | | | | | | | | | | Pr. Anne, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. MAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, "PASS" AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

[illegible]

055479 JUN - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

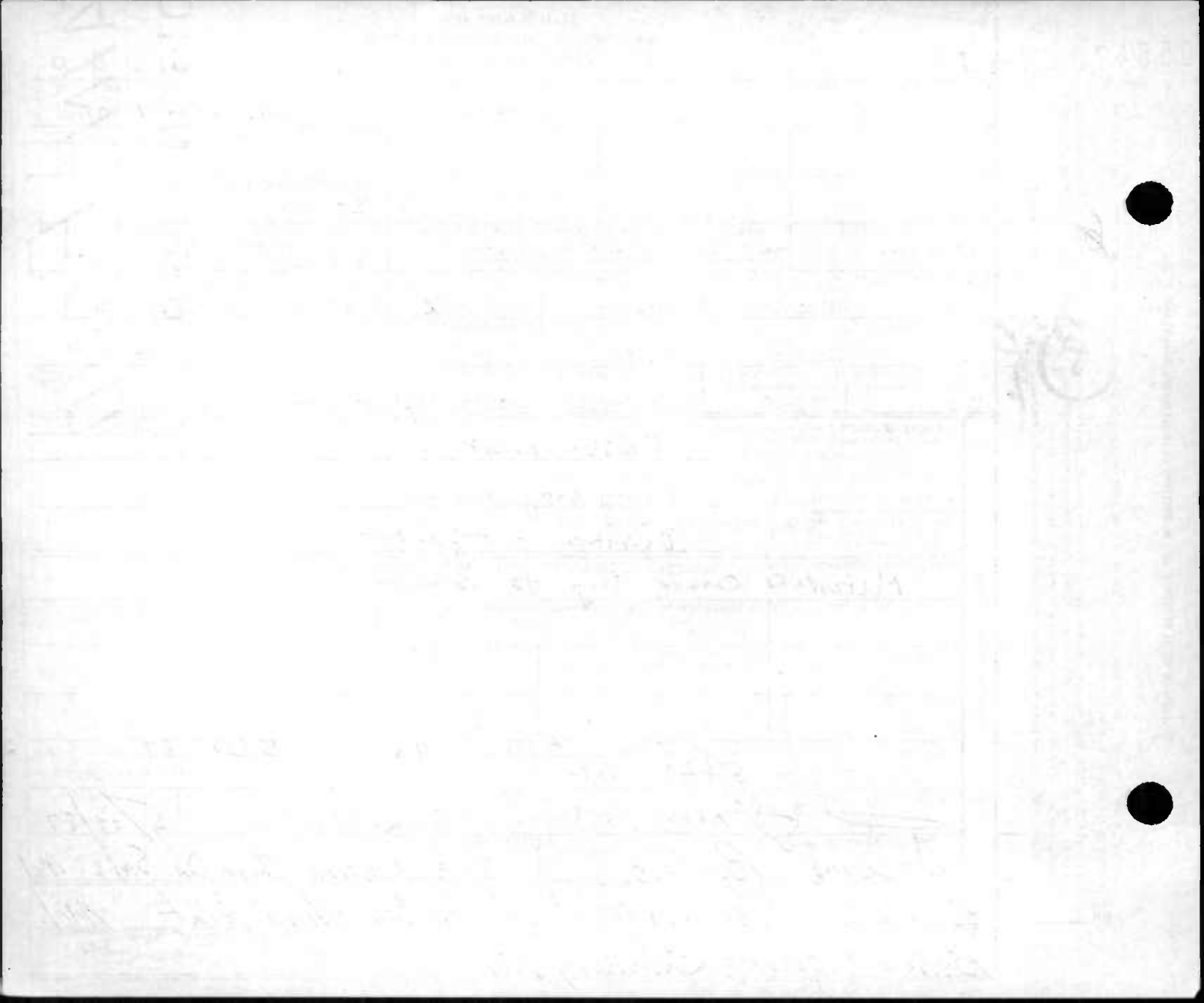
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15586

| | | | | | |
|---|--|--|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick A. WILLIAMS | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 29, 1987 | | 2b HOUR 0910 M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Apr. 7, 1926 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10 CITY OR TOWN OF DEATH Salisbury | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Chief | 12b KIND OF BUSINESS OR INDUSTRY City Gov't | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | 13b COUNTY Wicomico | 13c CITY OR TOWN Fruitland | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 412 Cartwright Ave. / 21801 |
| 4 FATHER'S NAME FIRST MIDDLE LAST W. Ernest Williams | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iva Mae Carey | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1946-48 | | 16b SOCIAL SECURITY NO. 215-20-0623 | 17 INFORMANT ADDRESS Bettie Williams same as 13e | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral artery aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dementia - Hypertension</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Mitostatic Cancer lung to Brain</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>6/11</u> 19 <u>76</u> to <u>5/29</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>J. J. Baker, M.D.</u> | | DEGREE | | 22c DATE SIGNED <u>5/29/87</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOSEPH BAKER</u> | | 22e ADDRESS <u>813 EASTERN SHORE DR. SALIS MD.</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (IF Y) | 23b DATE <u>5/31/87</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Washington Ch. Cem</u> | | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Shad Point Md.</u> | 23e DATE REC'D. BY REGISTRAR <u>JUN 3 1987</u> |
| 24 FUNERAL DIRECTOR NAME ADDRESS <u>Baker & Bounds, Salisbury Md.</u> | | 25a DATE REC'D. BY REGISTRAR <u>JUN 3 1987</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

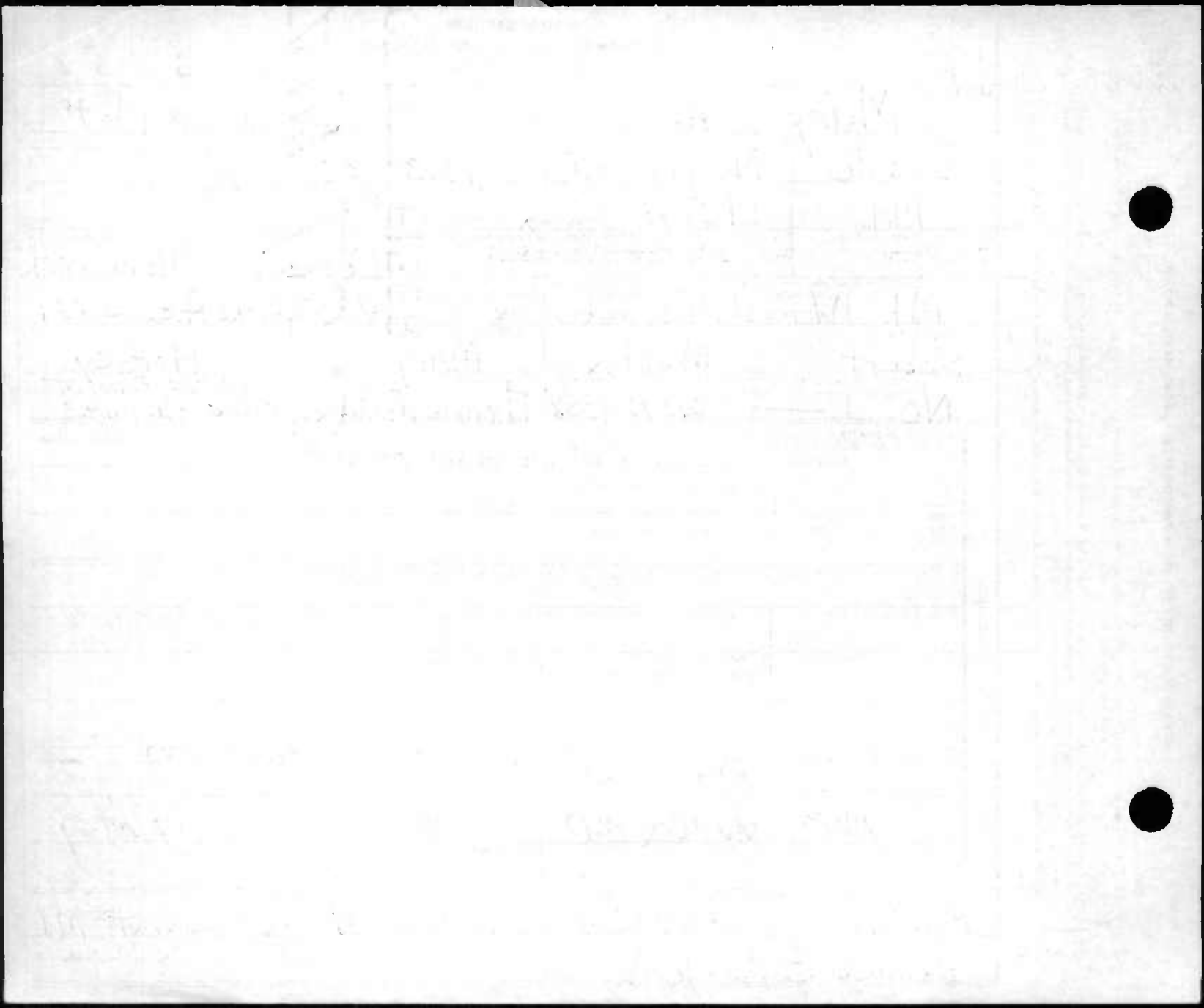
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 22 show early injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 15587

| | | | | | |
|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | Mary A. Wise | | May 19, 1987 5:30 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Female | Negro | Mar. 31, 1903 | 84 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | USA | | Wicomico MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | Peninsula General Hospital | Domestic | House work | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | Worcester | Pocomoke | | 935 Clarke Ave. 21851 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| Robert Maddox | Mary Horsey | No | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 213-16-8358 | Thomas Maddox | 1439 S. Fallor St Phila, Pa. 19143 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/19 19 87 to 5/19 19 87, that (I) (we) last saw the deceased alive on 5/19 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE M.B. Mazer MD | | DEGREE | | 22c. DATE SIGNED 5/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5-23-87 | | Centennial U.M. Cem. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE | | 24c. LOCATION CITY OR TOWN COUNTY | |
| Samuel G. Savage | | JUN 3 1987 | | Klester Somerset Md. | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| JUN 3 1987 | | John R. Randle | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FRED D. WONGUS | | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-87 | | 2b. HOUR 4:45 P.M. | |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 12-19-1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riner Walk Manor | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Retired |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. COUNTY Dor. | | 13b. CITY OR TOWN Vienna | | 13c. STREET ADDRESS / ZIP CODE P.O. Box 64 21869 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mitchell Wongus | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 217-30-9145 | | 17. INFORMANT James Young | | ADDRESS P.O. Box 64 Vienna 21869 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> 19 <u>87</u> , to <u>5-12</u> 19 <u>87</u> , that (I) (we) last saw the deceased <u>5-12</u> 19 <u>87</u> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>John C. Boardley</u> | | DEGREE MD | | 22c. DATE SIGNED 5-13-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.H. Boardley | | 22e. ADDRESS River Walk Manor Salis., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5/18/87 | 23c. NAME OF CEMETERY OR CREMATORY Thompson Town Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Thompson Town Dor., Md | |
| 24. FUNERAL DIRECTOR NAME L.H. Boardley | | ADDRESS 812 Hubbard St. Camb, Md. | | 25a. DATE REC'D. BY REGISTRAR MAY 19 1987 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

